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ABSTRACT

A complete outline is presented of a 2-day, 10-hour training program for establishing a student assistance program dealing with the problems of alcohol and drug abuse. The sessions are presented in the following sequence: (1) registration and introductions; (2) presentation of the problem; (3) clarification of expectations and establishment of a learning contract; (4) the impact of addiction upon the individual user; (5) adolescent development; (6) the impact of chemical dependency upon the family; (7) symptoms and survival skills of children of alcoholics; (8) enabling systems; and (9) changing systems' enabling patterns. Activities, work sheets, discussion topics and demonstration charts are included for each session. A bibliography is included. (JD)

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Alcohol and Drug Defense Program
Substance Abuse Intervention
10-Hour Training Module

Introduction To Student Assistance Programs

August, 1988

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P R E F A C E

This manual has been developed as a suggested guide in presenting basic substance abuse intervention strategies. ADD staff and other school personnel are encouraged to use this manual as a training tool.

ACKNOWLEDGEMENT

This ADD 10-Hour Training Module borrows greatly from established resources in this field. Notable references drawn upon include: Jim Palmer's previous edition of this module; Gary Anderson's book, When Chemicals Come to School: The Student Assistance Program; Jim Crowley's two books, Alliance for Change and One Step Ahead. We are most grateful for permission from the North Carolina Department of Human Resources Division of Mental Health, Mental Retardation and Substance Abuse Services for their permission to draw directly from their manual, Adolescent Substance Abuse Training for Youth Professionals, Level I Training Manual (Sessions V-VII in this module are re-formatted versions of that reference).

Special thanks go to Marianne Gemming from the Chapel Hill-Carrboro School System for her advice in critiquing the training plan. As always, nothing leaves this office without the admirable effort and editing of the ADD support staff.

Rob Young

Rob Young
Intervention Specialist

INTRODUCTION TO STUDENT ASSISTANCE PROGRAMMING

AGENDA

DAY 1

9:00-9:15	Introduction And Review Of Program Logistics
9:15-10:15	Why Are We Here?: Establishing A Learning Contract
10:15-10:30	Break
10:30-11:30	The Impact Of Addiction Upon The Individual User
11:30-12:30	Lunch
12:30-12:40	Energizer
12:40-1:45	Adolescent Development
1:45-3:00	The Impact Of Addiction Upon The Family
3:00-3:30	Discussion And Closure

DAY 2

9:00-9:15	Review Of Previous Day's Learning
9:15-10:15	Children Of Alcoholics: Beyond Survival
10:15-10:30	Break
10:30-11:30	Enabling In Systems
11:30-12:30	Lunch
12:30-1:30	Consensus Building Exercise
1:30-3:00	The Student Assistance Program: Basic Elements and Functions
3:00-3:30	Evaluation And Closure

Session I REGISTRATION AND INTRODUCTIONS

OBJECTIVES: Participants will

- Register
- Meet the Trainers
- Get acquainted with one another

MATERIALS NEEDED:

- Registration forms
- Name tags
- Certificate Renewal information
- Participant materials packet
- Refreshments

ACTIVITIES: (30 minutes)

1. Following registration Trainers introduce themselves with a brief statement of their professional backgrounds and interest in this topic.

2. Make announcements regarding administrative business that might be required. Examples would include: Certificate Renewal information, parking, provision for breaks, location of rest rooms, etc.

3. Participants introduce themselves to one another.

   (a) Simple introduction stating background, interest in the subject and personal expectation for the workshop.

   (b) Depending on number of participants and available time, consider an optional introductions game (as energizer).

SESSION II PRESENTATION OF THE PROBLEM

OBJECTIVES: Participants will

- Be more familiar with student drug-abuse patterns as revealed in the 1987 ADD Statewide Survey.
- Be more familiar with historical approaches to the problem of student drug use and abuse.
- Be encouraged to discuss their personal perceptions of the impact of student drug use upon school and community.

MATERIALS NEEDED:

- Transparencies from ADD Survey
- Overhead projector

ACTIVITIES:

1. Lecture presentation using transparencies
2. Small group discussion

INTERVENTION LEVEL I: TRAINING MODULE

Session II

Activity 1

TIME	PURPOSE	SETTING	MATERIAL
15-20 Minutes	Lecture presentation on problem of student drug use	Large group	ADD Survey transparencies

PROCEDURE

Using Survey information and information from Chapter One of When Chemicals Come To School, present overview of student drug-use problem.

INTERVENTION LEVEL I: TRAINING MODULE

Session II

Activity 2

TIME	PURPOSE	SETTING	MATERIAL
15-20 Minutes	Conduct small group discussions to illicit personal response to lecture presentation	Small group	

PROCEDURE

1. Divide into small groups to discuss individual perceptions of what has been presented.
2. Small groups report out to large group.

SESSION III CLARIFICATION OF EXPECTATIONS AND ESTABLISHMENT OF A LEARNING CONTRACT

OBJECTIVES: Participants will

- List personal expectations for this workshop
- Share expectations with other participants
- Review Trainers' objectives and expectations
- Establish a consensus from a learning contract through negotiation with Trainers

MATERIALS NEEDED:

- Paper and pens/pencils
- Newsprint of flip chart paper and markers
- Easel for blank paper
- Masking tape
- Prepare on newsprint or flip chart paper the following
  - Workshop Syllabus (Trainers' objectives)
  - "Gives To Gets" list
  - Non-negotiables

ACTIVITIES:

1. Complete "Curriculum Contract"

INTERVENTION LEVEL I: TRAINING MODULE

Session III

Activity 1

TIME	PURPOSE	SETTING	MATERIAL
60 Minutes	Establish a Learning Contract	Small group to large group	See previous page

PROCEDURES

1. Distribute paper and have participants list all their responses to the following statement: "I came here to get..." (encourage specific responses).
2. Instruct participants to form small groups of between 6-8 members and to share their lists. Each group is to select a recorder who will compile that group's list of expectations.
3. Recorders report out to large group. Trainers write down each different expectation on large paper to create a master list that all can see.
4. Post "Workshop Syllabus" and compare to master list from participants.
5. Synthesize both lists. Add or delete as negotiated by the group.
6. Ask participants to brainstorm "What are you willing to give to get the curriculum accomplished?" Post their responses.
7. Post Trainer "Gives to Gets" list.
8. Post "Non-negotiables" (no smoking, must attend all sessions, etc.)
9. Ask for approval of curriculum contract as negotiated.
10. Indicate that you will review this contract with the group at the end of training to find out how well the task was accomplished.

TRAINER "GIVES TO GET" LIST

(SUGGESTED ITEMS TO INCLUDE AND POST)

- Share knowledge, experience
- Variety of presentation methods
- Listen to you
- Provide clarification
- Keep us on task
- Maintain schedule
- Sensitive to your needs

(SUGGESTED "NON-NEGOTIABLES" LIST)

- Drinking, eating, and smoking only in designated areas
- Must attend all sessions

SESSION IV **IMPACT OF ADDICTION UPON THE INDIVIDUAL USER**

OBJECTIVES: Participants will

- Review their understanding of chemical dependency, particularly as applied to adolescents.
- List common defense mechanisms and the function they provide.
- Describe the defense structure of a chemically dependent person and the function this structure provides.

MATERIALS NEEDED:

- Flip chart/markers or blackboard/chalk
- Handouts (Optional): "Identification of Defenses," "Defense Mechanisms," "Brainstorming About Defenses," "The Feeling Chart,"
- Overhead transparency of "The Feeling Chart"
  (Optional) Lecture Guide: "Chemical Dependency"
- Overhead projector

ACTIVITIES:

1. Review participants' previous instruction regarding the stages of adolescent chemical use/abuse (if no previous training has addressed this subject see Prevention Module Session V).
2. (Optional) Introduce discussion of defense mechanisms with either of the following exercises
   (a) Identification of Defenses
   (b) Brainstorming About Defenses
3. Using overhead, blackboard or flip chart, present "The Feeling Chart" lecture.

INTERVENTION LEVEL I: TRAINING MODULE

Session IV

(Optional) Activity 2

TIME	PURPOSE	SETTING	MATERIAL
15 Minutes	Introduce discussion on the subject of defense mechanisms	Large group	Handouts: "Brainstorming About Defenses," "Identification of Defenses," "Defense Mechanisms"

PROCEDURE

1. Distribute Handout "Defense Mechanisms" and instruct participants to read this explanation.

2. Simply discuss this handout or choose to enlarge upon the topic by completing one of the following worksheets, "Brainstorming About Defenses" or "Identification of Defenses."

3. Discuss

DEFENSE MECHANISMS

Definitions:

Defense mechanisms are mental processes that we use to protect ourselves from some aspect of ourselves or our lives that we perceive to be unpleasant, uncomfortable or threatening to us. There are many defense mechanisms which we all use. Use of these defenses is usually normal, healthy and necessary to maintain moneal and physical health. They protect us from traumas that might otherwise overwhelm us. We use different defenses to different degrees. These defense mechanisms are generally triggered automatically and unconsciously.

However, for the chemically dependent person, use of the defense mechanism is harmful because their use is exaggerated and it blocks out reality. As a result, the use of defenses is a major symptom of their illness, and is sometimes referred to as the "denial system". Chemically dependent individuals use relatively few defenses and their use becomes progressive (i.e., they tend to use them more and more and they use one or two devense mechanisms to the exclusion of others). Because of this, the defense system becomes very difficult to penetrate and break down.

Commonly used defenses:

DENIAL	Refusing or incapable of recognizing the unpleasant situation or behavior.
MINIMIZING	Making the problem appear much less serious or significant that it actually is.
RATIONALIZATION	Making excuses, usually reasonable, which are less unpleasant that the real reason for what has been said or done.
INTELLECTUALIZATION	Recongizing a problem exists but talking about it in a philosophical, detached manner with no personal feeling or involvement.
PROJECTION	Placing responsibility for the unpleasant event or characteristic onto someone or something else.
DIVERSION	Changing the subject to avoid the threatening topic.
HOSTILITY	Becoming angry, aggressive or argumentative when reference is made to the problem and related behavior. This tends to avoid the issue by backing people off.

TITLE:	Identification of Defenses
OBJECTIVE:	To be able to recognize the defenses people use to mask their feelings.
PROCEDURE:	Go over handout. Direct students to identify their own defenses from the list. After they have completed this, have them determine what feelings were hidden. Solicit comments, examples, etc., from group members.
MATERIALS:	Handout on "Defenses"

DEFENSES	HOW PEOPLE SEE US	POSSIBLE HIDDEN FEELINGS
Explaining		
Justify		
Intellectualize	Superior	
Rationalize	Arrogant	
Minimize	Controlled	
Theorize	Manipulative	
Analyze		
Switch		
Generalize		
Glaring	Stubborn	
Disagree	Defiant	Inadequate
Sarcasm	Hostile	Angry
Threatening	Angry	Sad
Attacking		Afraid
		Ashamed
Agreeing	People - Pleaser	Hurt
Flattering	Nice Guy	Guilty
Joking	Wishy-Washy	Loneliness
Smiling	Phoney	
Apologetic		

For All Defenses

DEFENSES	HOW PEOPLE SEE US	POSSIBLE HIDDEN FEELINGS
Minimizing	Aloof	
Evading	Indifferent	
Switching - Shifting	Rejecting	
Silence	Sullen	
Withdrawing	Suspicious	
Running - Away		
Projecting		
Critical	Angry	
Moralizing	Resentful	
Rationalizing	Intolerant	
Judgmental	Martyr	
Justifying	Self-pity	
Attacking		
Excuses		

BRAINSTORMING ABOUT DEFENSES

1. List some "defense mechanisms" and coping strategies you know you use. (Examples: denying, exaggerating, joking, blaming, etc.)

2. Under what conditions are you likely to employ them?

3. What defense mechanism do you think chemically dependent people use? Under what conditions do you think they use them?

4. How can "defense mechanisms" affect the problem-solving process?

5. How will knowing about denial systems and defense mechanisms help you identify and refer substance abusing adolescents?

INTERVENTION LEVEL I: TRAINING MODULE

Session IV

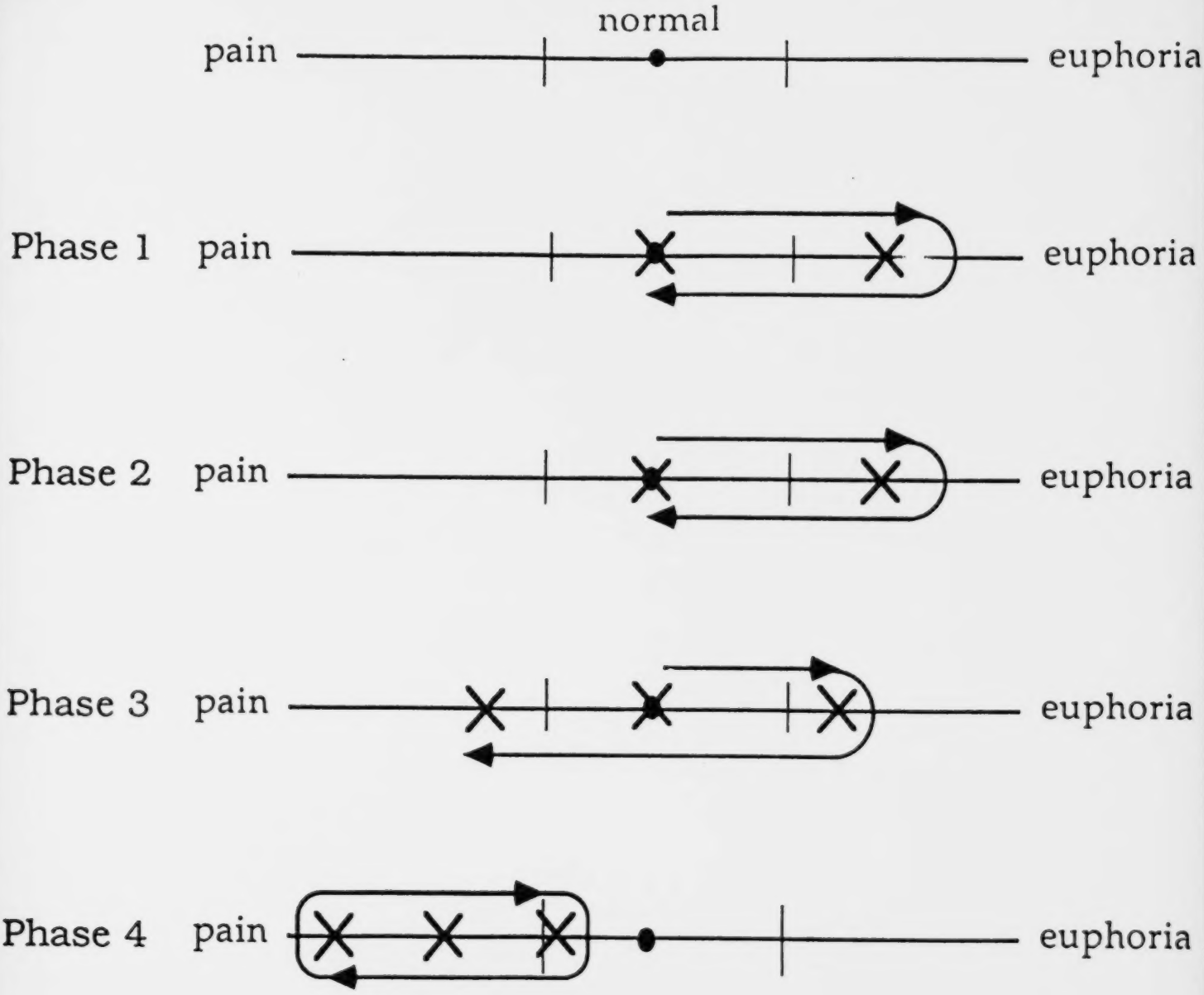
Activity 3

TIME	PURPOSE	SETTING	MATERIAL
45 Minutes	Lecture/discussion on "Feeling Chart"	Large group	°Overhead transparency "The Feeling Chart" °Flip chart/markers or chalkboard/chalk °Handout: "The Feeling Chart" °Lecture Guide: "Chemical Dependency"

PROCEDURE

1. Choose to use either overhead transparency or flip chart/blackboard.

2. Using Lecture Guide, give presentation on Feeling Chart. Be sure to apply these concepts to adolescent experience of mood-altering chemical use.



The Feeling Chart Transparency

LECTURE GUIDE

CHEMICAL DEPENDENCY

Chemical dependency is the state of being addicted to mood altering drugs to the extent that it seriously and consistently causes problems for the individual. Physical addiction can effectively be dealt with through detoxification efforts. In addition to the physical addiction, there is the much more difficult and complex problem of psychological addiction.

Everyone who is chemically dependent/alcoholic experiences a universal emotional pattern that can be illustrated through the use of the Feeling Chart. This is essentially a straightline graph where all human emotions can be represented. The mood swings which are the emotional symptoms of alcoholism are shown on successive graphs as we trace the inevitable deterioration of the self-image of the suffering alcoholic. (See Figure 1)

In Figure 1, human feelings are registered graphically from left to right. The most painful feelings at the far left merge into less painful ones, which shade into normal feelings and ultimately build to ecstatic emotions or the euphoria depicted at the far right of the graph. For the purpose of illustrating the dynamics of alcoholism or mood swings, the chart can be useful to us as a tool. Moods range from "I'm okay," to "I'm blissful." We can assume that the great majority of persons are emotionally more or less comfortable and therefore in the middle of the chart.

We use the Feeling Chart to record the drinking experience of the alcoholic from the first phase, or introduction to ethyl alcohol, to the first instance of emotional cost which signals the onset of the disease, and finally to the last fatal stage which may be either slow or rapid suicide. There are four different phases that the chemically dependent/alcoholic person will pass through: 1) discovering or learning the mood swing; 2) seek the mood swing; 3) harmful dependency (alcoholism); 4) drinks to feel normal.

The first two phases of the Feeling Chart, discovering or learning the mood swing, are entirely pleasant and benign. They describe the experiences of all drinkers, not just alcoholics. The individual is introduced to some beverage containing ethyl alcohol (wine, beer, or distilled spirits) and in our culture this will be very early in life. In terms of the Feeling Chart, that first drinking experience is a mood swinger, in a positive direction - it gives the drinker a warm, good feeling, may even make him giddy, depending upon the amount. And when the effects of the alcohol wear off, the drinker returns to normal (see Figure II). There is no damage, there is no emotional cost. On the chart, he goes from 1 to 2, then swings back to 1 again, when the effect disappears.

There are three steps in the new drinker's learning experience:

1. Alcohol always moves him in the right direction.
2. He can control the mood swing by the amount.
3. Alcohol works everytime.

How is the person learning? It is not intellectually, such as from a lecture. The person is learning intellectually, by doing it and this person is learning by feeling it, or emotionally, which is the very best way to absorb anything.

If the person continues to drink, he will eventually develop a relationship with the alcohol. This relationship with alcohol is positive rather than negative. It is based on implicit trust, built in more and more strongly as experience proves that booze will do its job for him every time. Experience builds on experience and consolidates it, and the result is a deeply imbedded relationship which he will carry through the rest of his life.

During Phase Two, a person can be classified as a social drinker and may even get drunk. At this time, the drinking probably is not a problem and the person might experience a hangover. He is able to pay this physical price that is exacted by his drinking, but he is not paying any emotional price at this point.

As a social drinker gets deeper into his chemical, getting drunk begins to have a very different effect on him. Eventually, he will enter Phase Three, which is alcoholism, by becoming harmfully dependent on alcohol and/or drugs. The index of the progress of the disease is the degree of the <u>emotional cost</u>. Graphically, the emotional price paid is recorded on the Feeling Chart in terms of the mood swing back beyond normal toward pain (see Figure IV).

The third phase of alcoholism opens with the onset of the disease in recognizable form. This phase is characterized by harmful dependency and a rising emotional cost. Eventually, a significant and progressive deterioration of the personality of the alcoholic will occur and finally a visible physical deterioration.

Emotionally, the alcoholic is overwhelmed somewhere in that terrifying backfiring of mood, and intellectual defenses rise in him against the emotional punishment. Drinking has become uncomfortable for him. He can no longer successfully pretend that it was worth it. He will instinctively, and with no particular notice of what he is doing, rationalize his feelings about himself. "I know why that heppened," he will say about some particularly unyielding experience. "I did that on an empty stomach. Nobody can drink three martinis in an hour on an empty stomach."

As the process of alcoholism continues, repeated shamful, painful, unpredictable and compulsive patterns of behavior persist over a long period of time. And as they grow more painful and shameful, rationalization rises to the challenge. In short, as time goes on, he continues to believe more and more of the fairly plausible part of these efforts to restore his sense of dignity and self worth. The ultimate general effect is to draw him quite literally out of touch with reality.

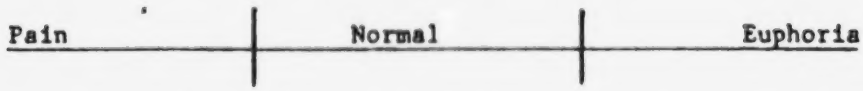
The final stages of alcoholism are at hand (see Figure V). Continued excessive drinking and accompanying behavior being on chronic suicidal feelings. Self-appraisals runs: "I'm no damn good," "I'm so rotten, I might as well end it all." Drinking or not drinking, suicidal thoughts start flashing through the mind.

As emotional distress mounts and the deterioration of personality accelerates, there are all sorts of behavioral changes. For the alcoholic, these changes occur in his lifestyle: 1) growing anticipation of the welcome effect; 2) an increasing rigidity around the expected time of use, and; 3) a progressive ingenuity in obtaining larger and larger amounts of alcohol.

If the illness is not interrupted, the alcoholic will enter the fourth and final stages of alcoholism, in which the subject drinks to feel normal. Several things begin to happen during this final stage of the illness. 1) rational defenses of the alcoholic lock in his negative feelings of anxiety, guilt, shame, remorse, and self hate; 2) he projects this self hate onto those around him, 3) people close to the alcoholic begin to feel guilty when he dumps his self hate onto them, and; 4) finally, in response to their feelings of guilt and shame, the family members will start to rationalize (see Figure V).

The above material is taken from "I'LL QUIT TOMORROW," by Vernon E. Johnson

THE FEELING CHART



I. DISEASE: Chemical dependency (alcoholism and/or drug addiction) is a disease. A disease has its own symptoms and is describable.

A. PRIMARY DISEASE: It is not a secondary symptom of something else.

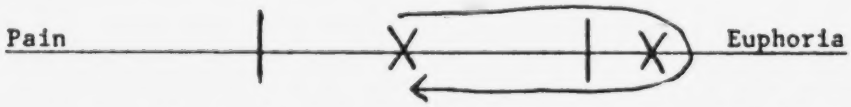
B. PROGRESSIVE DISEASE: it gets progressively worse. The victim becomes physically, spiritually, emotionally and psychologically ill.

C. CHRONIC DISEASE: There is no cure. Recovery from the disease must be based on abstinence from mood-altering chemicals.

D. FATAL DISEASE: The disease can only be arrested. If it is not arrested, the person will die from it.

Progression of the Disease

II. PHASE #1: LEARNING THE MOOD SWING (AUTONOMIC LEARNING)



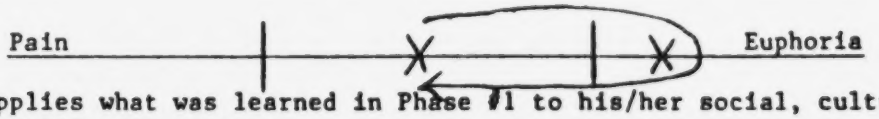
A. Learns that chemicals can provide a temporary mood swing in the direction of euphoria.

B. Learns that chemicals will provide this positive mood swing every time they are used.

C. Learns to trust the chemical and its effects.

D. Learns to control the degree of the mood swing by regulating the quantity of the chemical intake.

III. PHASE #2: SEEKING THE MOOD SWING



A. Applies what was learned in Phase #1 to his/her social, cultural, and life situation.

B. Uses the chemical at the appropriate times and places.

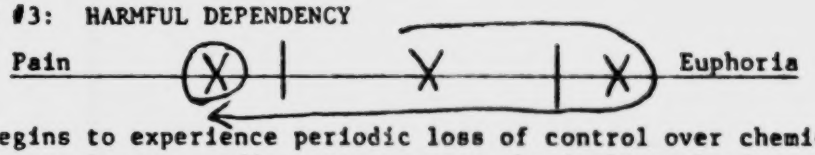
C. Develops self-imposed rules about the use of the chemical and adheres to them, e.g., "I don't drink until after five o'clock."

D. May suffer from physical pain (hangover) for an occasional overuse of the chemical but no emotional pain.

E. Continues ability to control the times, quantities and outcome of all chemical using experiences.

F. Social users remain in this phase. Victims of chemcial dependency progress to Phase #3.

IV. PHASE #3: HARMFUL DEPENDENCY



A. Begins to experience periodic loss of control over chemical use. Can no longer predict outcome once chemical use begins.

B. These episodes result in behavior that violates the person's value system and in turn create the first emotional pain that the victim experiences.

C. Spontaneous rationalizations arise and hide these feelings from the victim. This loss of insight becomes a growing delusion.

D. Negative feelings about self remain unidentified and therefore are unresolvable. This results in a growing chronic emotional distress.

E. Experiences growing anticipation and preoccupation with the use of the chemical.

F. Lifestyle begins to change and revolve around the chemical.

G. Specific times for chemical use are now established and rigidly held.

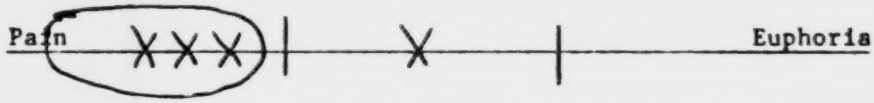
H. Self-imposed rules that were developed in Phase #2 are now regularly being broken.

I. Tolerance to the chemical increases causing the victim to develop more ingenious ways to get, use and keep the chemical, i.e., sneaking drinks, hiding bottles, etc.

J. Projections of self-hatred onto others begin to occur.

K. Victim's whole life is deteriorating as health, spirituality, emotional stability and interpersonal relationships become adversely affected.

V. PHASE #4: USING TO FEEL NORMAL



A. Using chemicals to survive rather than to feel euphoric.

B. Blackouts occur more frequently.

C. Tolerance built in Phase #3 breaks.

D. Physical addiction can occur.

E. Paranoid-like thinking is present.

F. Geographic escapes are made.

G. Loss of desire to live and a complete spiritual bankruptcy.

frequently-seen stages in

adolescent chemical use

by Dennis D. Nelson

how to use this chart

Adolescent drug abuse has increased rapidly in recent years, causing great concern for those who see how it damages their children or their students. This concern prompted our large suburban high school to initiate a program to identify and help students who are abusing drugs, including alcohol.

Two years of daily contact with these students form the basis for the pattern presented here. Hours of discussion with students — about their drug use, their self-images and their relationships with others — have revealed that drug abuse can quickly and severely damage them.

The chronology presented here is one which has been shown to be typical of the students we have worked with in our drug-abuse program. Naturally, not all students fit precisely into all of the stages shown here. Some of them may never get beyond the social-recreational usage level. But the chart does apply to a large majority of the students whose drug use is abusive.

We have used this chart in assessment interviews with students who have shown evidence of drug abuse. It enables the interviewer to show students and their families where the student is on the drug-use continuum.

The student's position on the chart can help to determine whether he or she needs a referral for primary in-patient treatment for chemical dependency, or whether some other kind of intervention is necessary. Regular counseling in a peer group setting or involvement with Alcoholics Anonymous may be appropriate for some students. In other cases, it is appropriate simply to alert the student and his or her family to the fact that a problem may exist.

Using this chart should not involve a game of "Is you is or is you not dependent?" The ideal situation involves the staff member talking with the student openly and honestly and exhibiting nonjudgmental acceptance of the student's attitudes and feelings. To achieve this rapport, honesty and sincerity are required of the staff member. Assuming that the student is dependent and that a series of cleverly worded questions will reveal this truth is a sure way to plunge the counselor-student relationship into an abyss of distrust and distortion.

Respect for the student is vital and cannot be faked. Most students have responded well to an attitude that says, "Let's talk and see if together we can come up with some kind of an idea about where you are with your drug use." The staff member *must* accept the student's use, wherever it may be on this chart, and not blame, accuse or threaten the student. To do so could possibly cancel the interviewer's chances of being of much help either to the student or to his or her family.

1978 by Dennis D. Nelson

1
experimental use

Junior-high-age students, especially boys, are great experimenters with various types of mood-altering substances. Some may never go beyond the experimental stage. They may decide that chemical use is not for them. But a majority of them will continue to experiment and become regular users. They will use beer and pot in this stage, and will learn to seek and enjoy the mood swings that these substances will provide. A child who exhibits abuse at this stage may be establishing a lifelong pattern. Or the chemical use may level off and stay at the "social-recreational" level, causing no intrapersonal conflict or externally harmful consequences. It is difficult to assess chemical dependency at this stage. The normal turmoil of adolescence is baffling to both teenagers and their parents, and caution is advised in any evaluation procedure. Many students have been inappropriately labeled as dependent when in fact they are not. They may be using drugs, but that fact alone does not make them dependent.

2
more regular use

Simply using more does not, by itself, indicate dependency. But a pattern of regular use, coupled with some adverse behavioral changes, can show a definite move towards possible dependency. The point here is not how much is being used, or how often, but why it is being used and what behavioral changes occur as a result of the use. If teenagers have to lie to their parents about their savings accounts, about why they have dropped out of school sports or other activities, or about who their companions are, and have to maintain these fictions in order to continue using drugs, they will begin to experience real guilt. Unfortunately, this guilt produces feelings of intense self-hate, which results in increased drug use. A cycle of use-guilt-remorse-increased use begins.

3
daily preoccupation

Preoccupation with drugs is one of the major indicators of a chemical problem. More and more of the student's time, energy and money are spent on thinking about being high and insuring that a steady supply of drugs is available. Questioning a user at this stage will reveal that very few of his or her daily activities do not include drug use. The user accepts this as normal. Problems with parents or police may serve to cause the abuser to decide that it would be smart to cut down or to quit using all together. And they may succeed for a few weeks. Generally though, these periods of abstinence will not last. They do serve, however, to strengthen the abuser's sincere delusion that, because he or she "quit," there is no problem. It can be pointed out to the abuser that, even though he or she feels that there is still a choice as to whether or not to use, the "choice" is always the same: to keep using.

4
dependency

By the time the user has reached a state of dependency, negative personal feelings have been building steadily until they require daily, even hourly, medication with drugs. Abusers in this state are unable to distinguish between normal and intoxicated behavior. To them, being high is normal and no rationale or moral argument can break through their chemically maintained delusion. This delusion persists even in the face of overwhelming evidence that his or her abuse is out of control and is physically, mentally and emotionally strangling him or her. The abuser will continue to insist that there is no problem, that it is not out of control, and that he or she can quit at any time.

Frequently-seen stages in adolescent chemical use...

INTAKE		WHAT THE WORLD SEES
	1 experimental use	*Late grade school or early junior high years.*
1. Occasional beer-drinking, pot-smoking, or use of inhalants (glue-sniffing, sniffing aerosols, etc.). Usually done weekends or during the summer, mostly with friends.		Often unplanned, using beer sneaked from home, model glue, etc.
2. Easy to get high (low tolerance).		Little use of "harder" drugs at this stage.
3. Thrill of acting grown up and defying parents is part of the high.		
	2 more regular use	*Late junior high and early senior high years.*
4. Tolerance increases with increased use. More parties involving kegs, pot, possibly pills or hash. Acceptance of the idea that "everyone does it" and wanting to be in on it. Disdain of "local pot" or 3.2 beer. Staying out later, even all night.		More money involved, false ID's used. Alcohol or pot bought and shared with friends.
5. Use of wine or liquor *may* increase, but beer remains the most popular drink. Willing to suffer hangovers.		Parents become aware of use. May start a long series of "groundings" for late hours.
6. Consumption increases and pride in being able to "handle it" increases.		Drug-using friends often not introduced to parents.
7. Use on week nights begins, and school skipping may increase.		Lying to parents about the extent of use and use of money for drugs.
8. Blackouts may begin, and talk with friends about "What did I do last night?" occurs.		School activities are dropped, especially sports. Grades will drop. Truancy increases.
9. Solitary use begins — even smoking at home (risk-taking increases). Concentration on fooling parents or teachers when high.		Non-drug-using friends are dropped. Weekend-long parties may start.
10. Preoccupation with use begins. The next high is carefully planned and anticipated. Source of supply is a matter of worry.		
11. Use during the day starts. Smoking before school to "make it through the morning." Use of "dust" may increase, or experiments with acid, speed, or		

3 DAILY PREOCCUPATION

12. Use of harder drugs increases (speed, acid, barbs, dust).

13. Number of times high during the week increases. Amount of money spent for drugs increases (concealing savings withdrawals from parents).

14. "Social use" decreases — getting loaded rather than just high. Being high becomes normal.

15. Buying more and using more — all activities seem to include drug use or alcohol.

16. Possible theft to get money to insure a supply. There may be a contact with "bigger" dealers.

17. Solitary use increases. User will isolate self from other using friends.

18. Lying about or hiding the drug supply. Stash may be concealed from friends.

Possible dealing or fronting for others.

Possible court trouble for minor consumption or possession. May be arrested for driving while intoxicated. Probation may result.

May try to cut down or quit to convince self that there is no problem with drugs.

Most straight friends are dropped.

Money owed for drugs may increase. More truancy and fights with parents about drug use.

4 DEPENDENCY

19. Getting high during school or at work. Difficult to face the day without drugs. Drugs are used to escape self.

20. Possible use of injectable drugs. Friends are burnouts (and may take pride in the label).

21. Can't tell what normal behavior is any more — normal means being stoned nearly constantly.

22. Physical condition worsens. Loss of weight, more frequent illnesses, memory suffers, flashbacks may increase. Thoughts of suicide may increase.

Guilt feelings increase. Questioning own use but unable to control the urge.

Low self-image and self-hate. Casual sexual involvement. Continued denial of problem.

School dropped. Dealing may increase, along with police involvement. Parents may "give up."

Paranoia increases. Cost of habit increases with most of money going for habit.

Loss of control over use.

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FOUR CHARATERISTICS OF CHEMICAL DEPENDENCY

Richard O. Heilman (1975)

Heilman (1975) outlines four characteristics crucial to understanding chemical dependency, which we consider crucial in diagnosing the disease in adolescents.

1. Drug dependency is a recurrent, profound, overwhelming urge to repeat the experience of "getting high" or becoming intoxicated. The urge, when manifested from within, usually goes beyond the strength of one's will to do otherwise than take something.

2. The strength of this urge achieves primacy in the person's psychology. By that it is meant that the need to fulfill the experience of intoxication often-times transcends all other natural or learned needs. This urge, when manifested within the person, recurrently becomes stronger than sexual needs, stronger than the needs to satisfy hunger, stronger than even the need for survival. Very often, all other needs are rendered secondary in importance when the urge to repeat the experience of intoxification manifests itself.

3. The urge to become intoxicated becomes independent of any other aspects of our lives. Tension, depression, excitement, etc., can stimulate the urge or need to "take" something but are not necessary. The urge to become intoxicated can trigger itself as our other needs and "instincts" do. (The urge is automatic, not symptomatic!).

4. Once a person becomes hooked or psychologically dependent on a drug, this recurrent state of mind never leaves him. It is incurable. The experience of intoxication has been indelibly etched within the mind and remains the most intensely personal experience one can undergo. As time passes with sobriety or staying clean, the urge reduces its intensity and does not recur as often, but it does return.

SESSION V ADOLESCENT DEVELOPMENT

OBJECTIVES: Participants will be able to

- Recall some events from their own adolescence.
- Describe at least three tasks of normal adolescent development and the impact of chemical use upon successful completion of these tasks.

MATERIALS NEEDED:

- Overhead transparency "Recalling Adolescence."
- (Optional) Lecture guideline for "Adolescent Development."
- Worksheets for "Effects of Chemicals on Adolescent Development."
- Overhead projector.

ACTIVITIES:

1. Select one of three trigger activities designed to facilitate participant's recall of specific events from their own adolescence and the feelings attached to those events. (15 minutes)
2. (Optional) If expansion of cognitive information regarding adolescent development is desired (to set the stage for the next activity) consider giving a brief lecture presentation using the following guideline. (15-10 minutes additional time required.)
3. Using the following worksheets, conduct the "Effect of Chemicals on Accomplishing Developmental Tasks" activity. This is a small group activity with processing in the large group. (45-60 minutes)

INTERVENTION LEVEL I: TRAINING MODULE

Session V

Activity 1

TIME	PURPOSE	SETTING	MATERIAL
15 Minutes	Facilitate participant's recall of adolescent events and feelings	Large group	Overhead transparency

TRIGGER ACTIVITIES: Choose One

a) Using the overhead transparency "Recalling Adolescence," review each question and invite responses from the group as a whole.

b) Have participants pair off to respond to "Recalling Adolescence" questions. After partners have been selected give them one question to answer and share with one another, allowing 3-5 minutes for this interaction. Interrupt and have partners select new partners and continue in this fashion for 3-4 questions that you particularly like from "Recalling Adolescence" transparency. During this interaction facilitator should "float" among participants to observe the process. Reconvene and discuss the experience in the large group.

c) Ask participants to close their eyes, get comfortable and recall a memorable event when they were 12....14....16 years old. After five minutes encourage those who are willing to share their experience with the group.

RECALLING ADOLESCENCE

1. When did you first begin noticing physical changes in your appearance?

2. What was that experience like?

3. When did you first become aware of your sexuality?

4. What feelings accompanied your awakening sexuality?

5. When did you begin dating? What was it like?

6. Recall three emotions felt during adolescence.

7. How did your financial independence from your parents begin?

8. What were your friendships like? What did you talk about?

Overhead
Transparency

INTERVENTION LEVEL I: TRAINING MODULE

Session V

(Optional) Activity 2

TIME	PURPOSE	SETTING	MATERIAL
20-30 Minutes	Provide cognitive overview of adolescent developmental tasks	Large group	Lecture Guideline

Deliver a lecture based on the following notes:

Adolescence is a time of transition. It is a time when young people are emerging from a childhood identity and are struggling to develop in to an adult identity. Like any new learning process, adolescence is often a time of one step forward, two steps back.

Adolescence serves as an important learning ground for adolescents. Normal adolescent development involves a complex interplay of physical, psychological and social forces. Conflict, turmoil and rebellion are all a part of adolescence. Like the story told in a weavers rug, adolescence is a time of many seemingly incongruent forces coming together to hopefully produce a psychologically and physically healthy adult.

While adolescence is a time when self-doubt and conflict can reign supreme, it is also a time of enjoyment and new discovery. Studies focusing on normal adolescent development suggest that those adolescents who do well during this time of potential turbulence see this time as an opportunity to become competent and enjoy the environment around them.

Tasks of Adolescence

(As you describe the tasks of adolescents, ask participants to be thinking about their own adolescence and how they dealt with these tasks.)

There are three main tasks that adolescents attempt to master during this time of change. They are:

1. Develop coping mechanisms to handle physical and psychological changes.

2. Develop good interpersonal relationships with parents, teachers, and peers.

3. Achieve a sense of personal identity and autonomy from parents.

Session V
Activity 2 - Continued

1. Develop coping mechanisms to handle physical and psychological changes.

Physical change comes early for girls. The average onset of puberty is age 10 or 11, maximal growth occurring around 12 years of age, and menarche beginning between 11 and 13. Physiologically, girls have a head start on boys. Puberty and maximal growth for boys usually begins about two years later than for girls.

In addition to major physical development, sexual awareness becomes heightened. Much of the adolescent's behavior and interest revolves around sexuality since it is hard to avoid. In many ways, this new sexual awareness is a double-edged sword. Awakening sexuality is on one hand a welcome sign of maturity and on the other hand a source of uncertainty and potential conflict. The adolescent is constantly juggling the need for individual sexual expression and cultural standards and rules.

Most adolescents handle the increased sexual and aggressive drives by sublimating sexual and physical energy in social activities and sports. One coping strategy used by adolescents to deal with anxiety and limit guilt is humor. While sometimes appearing cruel, humor is often an adolescent's best device to ward off feelings of insecurity.

2. Develop good interpersonal relationships with parents, teachers, and peers.

Adolescence is in many ways a practice ground for adult life. The adolescent is constantly working on socialization skills. It is not uncommon for teenagers to be in many relationships over a short period of time. How many times have you heard a teenager say about his or her best friend "I hate her guts and I'm never going to talk to her again!"...and the next day you see them together looking as though nothing ever happened? Adolescence is a time of experimenting new skills in making meaningful relationships.

Certain social conditions make the passage through adolescence easier:

A. Meaningful adult roles. Adolescents need good role models to emulate as they develop their own social consciousness.

B. Stability and consensus in the value system of the society. Adolescents are constantly evaluating societal norms, looking for a niche that they can identify with and that will offer some security and stabilty.

C. Clearly defined transition points from child to adult status. Entering junior high is often perceived as an entry point into adolescence. Suddenly, the challenges are more intense, students are faced with responding to a series of teachers rather than just one, and are exposed to a wider range of peers than ever before. During

Session V
Activity 2 - Continued

this period there is cognitive growth which results in increased abstract thinking abilities. Exiting high school is often perceived as a transition into adulthood, as are getting a drivers license, owning a car, etc. Adolescents perceive these as important achievement markers on their way to independence and adulthood.

3. Achieve a sense of personal identity and autonomy from parents.

Another task of adolescence is to achieve autonomy from and equality with parents. Erickson described the major task of adolescence as establishing a stable identity. In order to achieve autonomy from parents, adolescents often turn to peer groups for support and identity. Eventually, (for a time) peer activities and standards begin to replace those of the family in importance. In addition to utilizing peers more than parents in an attempt to form a self-identity, adolescents also look for financial independence from parents as a way to establish a stable identity. This is why for many adolescents, getting a job and making their own money can seem more important than anything else.

Effective Coping

In a study of normal adolescents by Westley and Epstein (1969), they found that effective coping by adolescents was a result of four major factors:

1. Active engagement with the environment. This would include such activities as sports, active social life, job, etc.

2. Openness of family communication. Healthy adolescents in this study identified open communication patterns between family and friends.

3. Clear identification of problems. Problem areas were clearly defined, brought out into the open and dealt with.

4. Balance of power between parents. Healthy adolescents seemed to reside in families where there was a balance of power between parents and parental roles were clearly defined.

By the time a healthy adolescent is ready to enter young adulthood, he or she has experienced some identifiable changes which include:

- an increase in self-esteem
- stabilization of mood
- definable interests
- goal directed activity
- self control

INTERVENTION LEVEL I: TRAINING MODULE

Session V

Activity 3

TIME	PURPOSE	SETTING	MATERIAL
45-60 Minutes	Explore 7 basic tasks of adolescence and the effects of chemical use upon completion of these tasks	Small group to Large group	Worksheet on 7 Developmental Tasks

PROCEDURE

Group size permitting, divide participants into seven groups. Tell them that each of the groups will be assigned a different developmental task to discuss and will be given a worksheet to follow. Indicate, however, that their first task is to elect a discussion facilitator and a recorder. Once groups have identified these roles, distribute the developmental task worksheets, one to each group facilitator.

Groups will work on this task for 15-20 minutes. Your role is to assist these groups in staying on task by "floating" from group to group encouraging their efforts and clarifying instructions where needed.

Facilitate large group discussion by having individual group designees report out their findings, using the worksheet as a guide.

An alternative method for organizing this activity with smaller numbers of participants is to assign two or more developmental tasks to each group.

Effects of Chemicals on Adolescent Development

Developmental Task #1: Physical Maturation

Physical development is erratic and sometimes traumatic. Physical changes include body changes in height and proportions, development of facial and pubic hair, voice changes, enlargement of breasts or penis, and beginning of menstruation or first ejaculation.

1. How might adolescents think and feel about themselves during this change period?

   e.g., *insecure, ugly, gawky*

2. What are the potential long-term and short-term effects of chemicals on the adolescent's health?

   e.g., *vitamin depletion, AIDS, hepatitis, lung problems, overstressed physical system impaired hormone secretion (cocaine), loss of muscle tone due to lethargy and lack of exercise.*

Effects of Chemicals on Adolescent Development

Developmental Task #2: Cognitive Growth (Formal Operations/Piaget)

Adolescence is time to develop abstract thinking and reasoning abilities. Adolescents have a broadened knowledge base and are able to analyze their own thinking.

1. What kinds of changes occur as adolescents begin to reason abstractly and "think new thoughts?"

   e.g., ideas of their own, more thought about the future, flexible thinking, problem solving skills, able to process input form a variety of outside sources.

2. How might cognitive growth affect ways the adolescent makes decisions, solves problems, and expresses wants and needs?

   e.g., makes comparisons, reasons, likely to consider a variety of solutions then choose one, likely to apply systematic problem-solving strategies.

3. What happens to cognitive development if chemicals are used during this period?

   e.g., delayed, impaired, distorted

Effects of Chemicals on Adolescent Development

Developmental Task #3: Membership in Peer Groups

Adolescents are in limbo between childhood and adulthood. They are often either too young or too old and feel that adults don't understand them. Usually, they turn to friends for acceptance and reassurance.

1. How do peer groups affect the individual's personality development and behavior?

   e.g., provide security, group can affirm, part of socialization process, serve as role model, influence behaviors and values

2. How do peer groups affect the adolescent's relationships with adults (parents, teachers, counselors, authority figures)?

   e.g., can replace some authority figures, give adolescents support to challenge authority, can challenge parental rules and authority

3. How do adolescents behave among peers in order to have their social, emotional, and self-esteem needs met? What specific behaviors are evidenced?

   e.g., follow leaders or become leaders, try to fit in, dress according to group code, evaluate according to group's standards, schedule activities with peers

4. What happens to individuals when chemicals are introduced into peer groups?

   e.g., peer pressure, judgement diminished, conflict, change in behavior, need to make choices and maybe change groups, change in activities and interactions.

Effects of Chemicals on Adolescent Development

Developmental Task #4: Sexual Relationships

During adolescence boys and girls become interested in people as a resource for friendship, affection, and sexual experimentation. Dating may become the focus of social life, with success or failure in "love" becoming the source of happiness, sadness, or anxiety. Sexuality and related issues, such as popularity, emotional involvement, sexually transmitted diseases, and pregnancy are important at this time.

1. How might increased sexuality affect:

   a. emotions
      e.g., anxiety, curiosity, confusion, pride, embarrassment, stress

   b. values

      e.g., conflict, guilt, need to clarify

   c. sexual behavior

      e.g., increase seduction, experimentation, and frequency of sexual activity

   d. peer interactions

      e.g., flirting, teasing, approach/avoidance, new friendship circles, new topics and social activities.

   e. self-concept

      e.g., new self-concept (can have positive or negative effect)

2. What happens if chemicals are introduced during this stage? (Consider issues a-e above.)

   e.g., reduces impulse control, promiscuity increases, socialization suffers

Effects of Chemicals on Adolescent Development

Developmental Task #5: Autonomy, Independence from Parents

Adolescents strive for increased independence from their parents, but in fact they are dependent. Conflict may arise as a result of discrepancies among the adolescent's need to be assertive and independent, the adolescents skills and resources to achieve independence, and parental perceptions and expectations.

1. What kinds of control or power issues may arise from the adolescent's need for increased independence?

   e.g., money, curfew, rules, need to save face, need to make own decisions, consequences for own behaviors

2. What feelings, thoughts, and behaviors may emerge from this tension?

   e.g., arguments with parents, defiance, anger, frustration, criticism, self-doubt, fear

3. How might chemical use affect an adolescent's struggle to achieve autonomy and independence?

   e.g., retard it

Effects of Chemicals on Adolescent Development

Developmental Task #6: Internalized Morality

Older adolescents and young adults develop high-level belief and value systems. They select standards, values, and beliefs from among many systems in their environment, and eventually they internalize ones they have chosen.

1. What might happen when a person's standards, beliefs, and values differ from those of

   a. family?
   e.g., feels guilty, struggles to reconcile, hides them, defies them

   b. friends?
   e.g., finds new friends

   c. society at large?

   e.g., makes excuses, drops out

2. What happens when a person's chemical use contradicts his/her internalized value and belief systems?

   e.g., guilt, rationalization denial

3. How can familial chemical use affect the development of an adolescent's value and belief systems?

   e.g., create distorted systems that the adolescent struggles against or succumbs to (see modules 3 , 8 and 9)

Effects of Chemicals on Adolescent Development

Developmental Task #7: Career Choice

Older adolescents make educational choices and begin to tool themselves for careers and economic independence.

1. **What social and family pressures might exist during this stage?**

   e.g., be part of the "in" group, pressure for scholastic achievement, pressure to stay in school, pressure to make decisions about one's future

2. What behavioral and emotional issues are involved?

   e.g., outside pressure to study harder, balance social and academic events in life, competition, need to earn money

3. How might chemical use affect adolescents during this stage?

   e.g., interfere with academic progress, reduce motivation, preoccupation with chemicals may distort values and alter priorities, damage reputation, alter self-image

SESSION VI THE IMPACT OF CHEMICAL DEPENDENCY UPON THE FAMILY

OBJECTIVES: Participants will be able to

- Define family, as a system
- Identify characteristics of functional and dysfunctional families.
- Describe characteristics of a chemically dependent family system.

MATERIALS NEEDED:

- Overhead projector
- Overhead transparencies "Family Characteristics," "Discussion Topics for Soft Is The Heart of a Child,"
- Video - "Soft is the Heart of a Child" (VHS format or film)
- Participant handouts "Thumb Nail Sketch," "Chemically Dependent Families," "Families: Nurturing and Dysfunctional"
- (Optional) "Family Mobile" (see Activities)

ACTIVITIES:

1. "Identifying the Characteristics" activity will explore differences between functional and dysfunctional family systems.
2. (Optional) Create your own "Chemically Dependent Family Mobile" using inexpensive materials such as cardboard, coat hangers and clothespins. By adding more weight to one component (clothespins) the whole "system" shifts. You may want to use this again in the Session VII, Activity 1.
3. Video of film "Soft is the Heart of a Child" and follow-up discussion will highlight the impact of living within a chemically dependent family system.

INTERVENTION LEVEL I: TRAINING MODULE

Session VI

Activity 1

TIME	PURPOSE	SETTING	MATERIAL
20 minutes	Identify characteristics of functional and dysfunctional families. Apply to chemically dependent families	Large group or two smaller groups	Transparency "Family Characteristics" Handouts. "Thumb Nail Sketch" and "Families: Nurturing and Dysfunctional"

PROCEDURE

Point out that there are degrees of family functionality and dysfunctionality--functionality and dysfunctionality are more accurately represented by a continuum rather than as absolutes.

Describe a functional family and a dysfunctional family:

> **"A functional family tends to be nurturing, communicates well, and deals with problems satisfactorily. A dysfunctional family tends to be non-nurturing, communicates poorly, and does not deal with problems satisfactorily."**

Do this as a whole-group activity or divide into two groups and have one group brainstorm characteristics of functional families while the other group brainstorms characteristics of dysfunctional families, then have groups present to each other.

Show the "Family Characteristics" overhead transparency.

Ask participants to brainstorm behaviors and attitudes that are characteristic of functional families. (Write their responses on the overhead transparency. Suggest some ideas to stimulate thinking.)

Characteristics of Functional Families

- clear expectations
- discuss all topics openly
- share leisure time activities
- maintain sense of humor

Session VI
Activity 1 - Continued

Ask participants to brainstorm characteristics of dysfunctional families while you write their responses on the overhead transparency. (Suggest some ideas to stimulate thinking.)

Characteristics of Dysfunctional Families

- criticize
- punish
- selectively share information
- hide feelings

Ask participants to turn to "Thumb Nail Sketch - Chemically Dependent Families" handout and "Families: Nurturing and Dysfunctional" handout and compare their brainstormed list of characteristics listed in the handouts.

Characteristics

Functional	Dysfunctional

Overhead
Transparency

Families: Nurturing and Dysfunctional

Nurturing	Dysfunctional
People feel free to talk about inside feelings.	People compulsively protect inside feelings.
All feelings O.K.	Only certain feelings O.K.
Person more important than performance.	Performance more important than person.
Individual differences accepted.	Everyone must conform to strongest person's ideas, values, etc.
Each person responsible for own actions.	Lots of control criticism.
Respectful criticism and appropriate consequences for actions.	Punishment, shaming.
Few "shoulds."	Lots of "shoulds."
Clear flexible rules.	Unclear, inconsistent and rigid rules.
Atmosphere is relaxed.	Atmosphere is tense.
Joyous.	Lots of anger, fear.
Faces and works through stress.	Avoids stress.
People have energy.	People feel tired.
People feel loving.	Hurt, disappointed.
Growth is celebrated.	Growth discouraged.
People have high self-esteem.	People have low self-esteem.
Strong parental coalition.	Coalition across generations.

from Family Care Tree
Johnson Institute

Thumb Nail Sketch - Chemically Dependent Families

I. Multiple Issues
- physical (health care, hospitalization)
- psychological (stress, depression, anger)
- social-emotional (abuse, financial strain, job)

II. Dynamics
- multi-generational
- role reversals
- unresolved grief
- feelings of frustration and hopelessness
- denial
- conflict, aggression
- acting out
- over or under functioning
- inconsistent rules

III. Feelings
- minimized and denied
- emotional isolation
- elevated defense system
- minimal intimacy and affection
- maximized conflict and stress

IV. Rules (Shame-Based System)
- Conditional Love: Love given in exchange for certain actions or under certain conditions.
- Blame: If something doesn't happen, blame. Blame usually follows disappointment.
- Control: Manipulate and deceive to maintain power and be in control of all interactions.
- Conceal: Don't talk openly about addiction or abuse.
- Inconsistency: Don't expect constancy in relationships.
- Disqualify: Don't acknowledge feelings.
- Deny: Don't admit the problem exists.

INTERVENTION LEVEL I: TRAINING MODULE

Session VI

Activity 2

TIME	PURPOSE	SETTING	MATERIAL
40 Minutes	Share impact of living within chemically dependent family	Large group	°Film or video: "Soft Is The Heart Of A Child" °Transparency "Discussion Topics..."

PROCEDURE

The issues relevant to this module are shown in the first part of the video. Stop the video after 15 minutes when Brian tells his brother and sister to 'get your things'. Preview the film so you know where to stop it and so you can describe the remainder if necessary. Sequence just before you stop the film is: Dad hits Terry, Brian calls Dad an alcoholic, Dad leaves, Mom runs after Dad, camera pans each child, then Brian tells them to get their things. If participants request to see the remainder of the video, make arrangements to show it after the session.

Introduce the video.

"The video we are about to see depicts people and events that are representative of life in a chemically dependent family. (I will stop the video halfway through, but will arrange to show the remainder to those who are interested.)

DISCUSSION PROCEDURE

This can be a large group or small group activity.

Show "Discussion Topics for Soft Is The Heart" overhead transparency or display discussion topics on a chalkboard or flip chart.

Session VI
Activity 2 - Continued

Discussion topics are:

A. The children's responses to their environment.
B. Interaction between parents.
C. The relationship of each parent with the children.
D. The children's interactions with their parents.
E. Ways feelings are treated.
F. Ways problems are solved.
G. The characteristics of the family members.

The children are:

Brian - "Hero"
Terry - "Scapegoat"
Lisa - "Lost Child"

Ask participants to discuss their reactions regarding each discussion topic.

Ask participants to hypothesize the feelings of the children in the film, and list them on a chalkboard or flip chart. (Be sure to include any positive emotions the group can identify.)

Some possible emotions:

shame	anger
guilt	joy
fear	love
loneliness	resentment
embarrassment	sadness

Discussion Topics for "Soft Is the Heart Of A Child"

A. The children's responses to their environment.

B. Interaction between the parents.

C. Realtionships of parent to their children.

D. Children's interactions with their parents.

E. Ways feelings are treated.

F. Ways problems are approached.

G. Characteristics of the family members.

Overhead
Transparency

SESSION VII CHILDREN OF ALCOHOLICS:
SYMPTOMS AND SURVIVAL SKILLS

OBJECTIVES: Participants will be able to

- Identify four or more characteristics of children from alcoholic (or chemically dependent) households.
- Describe four major survival roles of children of alcoholic or other addicted parents.

MATERIALS NEEDED:

- Overhead transparency "Survival Roles"
- Video "Family Masks" (9 minutes) from DHR, Division of Mental Health, Mental Retardation and Substance Abuse Services
- 1/2 inch VHS tape player and TV monitor
- Overhead projector
- (Optional) Alcohol Sculpture Script (as substitution for "Family Masks")

ACTIVITIES:

1. Discussion of "Survival Roles" based on reflection to "Soft is the Heart of a Child" and transparency of classic roles.
2. Show video of "Family Masks."
3. Substitute Alcohol Sculpture Script for "Family Masks" if you are comfortable in setting up and processing family sculpture demonstrations.
4. (Optional) Conduct "Family Feelings" exercise.

INTERVENTION LEVEL I: TRAINING MODULE

Session VII

Activity 1

TIME	PURPOSE	SETTING	MATERIAL
15-20 Minutes	Discuss Survival Roles in chemically dependent families	Large group	°Transparency "Survival Roles" °Mobile (optional)

PROCEDURE

1. Discuss the function of survival roles in dysfunctional families. Emphasize that these are typical roles for many non-dysfunctional families **EXCEPT THAT** they are not rigidly applied as in chemically dependent households. Use transparency "Survival Roles" and reference to "Soft Is The Heart Of A Child" where:

Barbara (Mom)	"Enabler"
Brian	"Hero"
Terry	"Scapegoat"
Lisa	"Lost Child"

2. (Optional) Emphasize system imbalance and accommodating behavior through illustration with a mobile (See previous Session VI, Activity 2).

Survival Roles

Enabler

Puts aside own feelings, becomes responsible for the family.

Hero

Tries to improve the situation. High acheiver who works hard to save the family name, but feels inadequate.

Lost Child

Withdraws and is a loner. Usually tries to take care of own problems.

Scapegoat

Achieves recognition in negative ways; gets into trouble, gets hurt.

Mascot

Uses humor and charm to relieve family stress. The facade keeps the mascot from dealing with problems.

INTERVENTION LEVEL I: TRAINING MODULE

Session VII

Activity 3

TIME	PURPOSE	SETTING	MATERIAL
20-30 Minutes	Involve selected participants in a family sculpture demonstration	Large group	°"Alcohol Sculpture" Script °Sturdy chair

PROCEDURE*

1. Introduce this activity and describe family sculpture by stating something like the following:

   "I would now like to create a living mobile, of sorts, to help us gain a better sense and feel of how members of an alcoholic (or chemically dependent) family interact with one another. This is a family sculpture demonstration and I'm going to need 6 volunteers who would be willing to take part in this relatively low-risk activity. You won't have a speaking part and the only requirements are a creative mind and loose, relaxed flexible muscles..."

2. Follow the script given on the following pages. Assist players in their gestures, molding and encouraging expressive postures.

*NOTE: If you have never facilitated this type of demonstration and/or are uncomfortable with any form of role play, do not attempt this activity. A suggested prerequisite for this activity is reading one of the books on the subject of family dynamics and addiction listed in the bibliography. If on the other hand you have had experience leading and processing a family sculpture, you may want to enlarge this activity beyond the script. Stop the action at various points and have players report how they're doing in their roles.

ALCOHOL SCULPTURE

Concept: Designed to show the roles that members of an alcoholic family assume and why family therapy is important in dealing with alcoholism.

Roles: Narrator; Alcoholic; Spouse; Hero; Scapegoat; Mascot; Missing Child

Dialogue: Narrator addresses the audience and calls out each family member as they fit into his story and places them in the sculpture.

Narrator: (Enters stage with chair placed front & middle, addresses audience) In exploring the dynamics of alcoholism it is important to understand the dynamics of the family. So today we're going to show you an alcoholic and how the members of his family interrelate. Can I have your typical alcoholic please?

(Typical alcoholic enters stage and stands on chair) This is your typical alcoholic. What we're going to show is how this alcoholic's family actually support his drinking. Can I have the typical alcoholic's wife out here please?

(Wife enters stage and kneels on all fours on floor, directly in front of alcoholic. Alcoholic places one foot on wife's back) This is the person who takes care of the house, picks everything up after the alcoholic rips them apart. This is the person who calls up his boss and says he's sick, when he's been drinking all night long. And, as you can see here, she supports his drinking. Can I have the first child out here please?

(First child, "Hero", runs onto stage and raises one arm in the air victoriously, exchanges a warm and affectionate glance with Alcoholic and stands beside him. Alcoholic places arm around Hero's shoulder.) This is the kid who wins at everything . . . football hero, good grades. With a kid like this, how could the father be an alcoholic? Can I have the second child please?

(Second child, "Scapegoat", enters stage slowly, dejectedly, head down. Walks behind family and places him/herself away from them, with back to them. Alcoholic points at him/her.) This is the kid that gets all the blame in this family. She's the one that's always in trouble, at school, probably with the law. But someone has to take the blame for a problem, right? Can I have the third child here please?

(Enter the third child, "Mascot", running, poking other family members. Freezes in the closest open spot) You can understand why there'd be a lot of tension in this family. Well, this is the kid that acts as a steam valve. When everything is tense, this kid cracks a joke and everybody laughs and feels better.

There's another child in this family, which we're not going to bring out here, called the "Missing Child." When you ask a teacher about this kid, they say, "Oh yea, little Johnny who sits in the back of the room. Quiet kid." With everything else going on, this kid gets "elected" to pull out of the family.

Note: The Sculpture is now complete, with everyone frozen in their respective places.

Narrator: As you can see, everyone has a place and a part in the dysfunction of the family. So, when you're looking at an alcoholic family it is important to see where everyone fits in. Then you can begin to treat not only the family as a whole, but the alcoholic individual. At this point, a therapist can come into the situation and begin to treat the family as a whole. (Approaches Scapegoat) Since this is the kid in trouble, this is probably the reason why the family has sought outside help. So we'll take this child, get her into treatment (Moves Scapegoat and places behind chair. Scapegoat begins shaking the chair - "rocking the boat.")

Then we'll take the Mascot - hey, things are pretty tough on the inside, aren't they? And we'll get the Mascot into treatment. (Moves Mascot into position behind the chair, who joins Scapegoat in rocking the boat.)

Now we'll get the Hero into treatment. Victory can be pretty hollow sometimes, can't it? (Moves Hero into position behind the chair, who begins rocking the boat, too.)

Next we'll get Mom up off her knees. She doesn't need to be taking care of EVERYTHING. (Mom moves behind the chair with the kids.)

And we'll bring out the Missing Child. (Missing Child enters stage and joins others behind the chair.)

Now that everyone can explore themselves and their relationships to the alcoholic, we can topple the alcoholic from his drinking . . . (everyone shakes chair and the alcoholic falls from chair - all family members form a line with the father and join arms) and become a functional family unit. (Cast bow and exit)

(Appropriate for young adult and adult audiences)

INTERVENTION LEVEL I: TRAINING MODULE

Session VII

(Optional) Activity 4

TIME	PURPOSE	SETTING	MATERIAL
10-15 Minutes	Assist participants to gain an emotional sense of being part of a chemically dependent household	Small groups in large room	Space to move around

PROCEDURE

1. Divide participants into groups of between 8-12 members.
2. Have those groups count off by two's: one's become an inner circle. Two's form an outer concentric circle around the one's.
3. Instruct the one's to keep silent, put their heads down and hands to themselves.
4. Instruct the two's to slowly walk around the one's talking "behind their backs" the way they believe people talk about families where there is obvious alcoholism (chemical dependency).
5. Switch roles and places and repeat.
6. Have each of the groups form into one circle, join hands and share one "feeling" word about their experience of being in the inside circle.
7. Leader provides closure by summing up what's been presented during this session...acknowledges the powerful level of emotional empathy that can surface some painful feelings in this exercise...encourages groups to attend to one another and support those who may be having some difficulty reaching closure.

SESSION VIII ENABLING IN SYSTEMS

OBJECTIVES: Participants will be able to

- Define enabling as it is used in the field of chemical abuse and addictions.
- List four examples of enabling functions that occur within a school setting.
- Distinguish between individual and system enabling patterns.

MATERIALS NEEDED:

- Transparencies: "The Concept of Enabling," "Reasons For Not Getting Involved With Student Drug Problems," "Enabling: Reasons or Excuses," "System Enabling," "Quotations"
- Overhead projector
- Flip chart and markers
- Handout: "Professional Enabling"

ACTIVITIES:

1. Small group activity to demonstrate "naturalness" of enabling.
2. Lecture/discussion on enabling functions (using transparencies).

INTERVENTION LEVEL I: TRAINING MODULE

Session VIII

Activity 1

TIME	PURPOSE	SETTING	MATERIAL
30 Minutes	Facilitate participant grasp of "well-intentioned" enabling patterns from an individual standpoint	Small group and large group	° Flip chart and markers ° Transparency "The Concept of Enabling" ° Adequate space to move around

PART 1: Conduct "Trust Circle" activity (also known in New Games as Wind in the Willows).

1. Divide group into groups of 8-10 members, form circles.
2. Ask for volunteer from each group to: (a) stand in the middle of the circle (b) eyes closed (c) arms crossed across the chest (d) feet together, erect posture "as if a board went right through" (e) wait for further instructions.
3. Instruct other members from each group to form a tight circle around their volunteer, feet wedged against volunteer's feet, arms up, ready to pass the volunteer back and forth around the circle.
4. Instruct volunteers to keep feet planted, maintain erect posture and when ready fall into the group and allow themselves to be passed around.
5. Repeat this process for different volunteers. Continue for several minutes.

PART 2: Process Questions

1. Reform into large group.
2. Ask and record participants' responses to the following questions:

   a) "What were your reasons for catching the person in the middle?"
   b) "What did it feel like to catch the person?"

3. Present definition of enabling as it applies to chemical abuse. Show transparency "The Concept of Enabling."
4. Discuss this definition.

THE CONCEPT OF ENABLING

The enabling system consists of those ideas, feelings, attitudes and behaviors which unwittingly allow drug problems to continue or worsen by preventing the drug user from experiencing the consequences of his/her condition, in order to enhance, maintain, or promote the enabler's sense of well-being.

Overhead
Transparency

INTERVENTION LEVEL I: TRAINING MODULE

Session VIII

Activity 2

TIME	PURPOSE	SETTING	MATERIAL
20-30 Minutes	Assist participants to identify examples of enabling functions: individually and collectively	Large group	°Flip chart or chalkboard °Transparencies: "Reasons For Not Getting Involved..." "System Enabling" "Enabling: Reasons or Excuses," "Quotations" °Handout: "Professional Enabling"

PROCEDURE

1. Ask participants for reasons they have heard for schools not getting involved with student drug problems. List their response on flip chart or chalkboard.

2. Show transparency "Reasons For Not Getting Involved With Student Drug Problems" and/or "Enabling: Reasons or Excuses." Ask for additional examples.

3. Show transparency "System Enabling" which asks the questions:

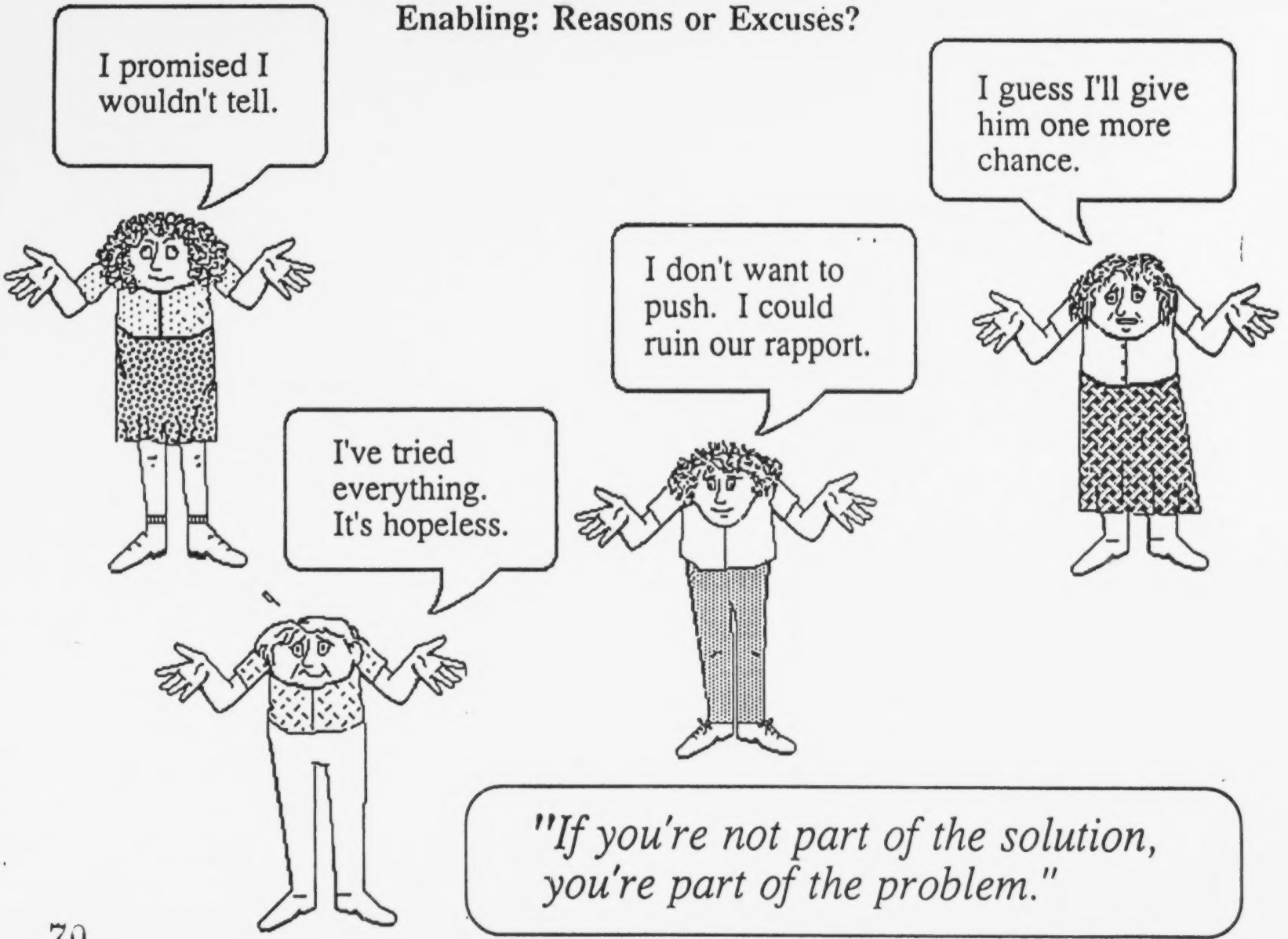
   "How are various enabling beliefs, feelings, attitudes and actions reflected in our collective behavior?"

   "What is our system's response?"

   Discuss

4. Close out with distribution of homework assignment "Professional Enabling" and display of "Quotations" transparency.

Enabling: Reasons or Excuses?


I promised I wouldn't tell.
I've tried everything. It's hopeless.
I don't want to push. I could ruin our rapport.
I guess I'll give him one more chance.

"If you're not part of the solution, you're part of the problem."

Overhead Transparency

SYSTEM ENABLING

How are various enabling beliefs, feelings, attitudes and actions reflected in our collective behavior?

What is our System's response?

REASONS (EXCUSES) FOR NOT GETTING INVOLVED WITH STUDENT DRUG PROBLEMS

- Not my job - I teach my content area!
- I got enough to do without getting into students' personal lives.
- I don't have the expertise to help in that area.
- I might get sued!
- I drink some myself, so I can't help.
- It's just hopeless -- "good kids" aren't going to use and "bad kids" will no matter what we do.

Overhead Transparency

Supplement 5.1

PROFESSIONAL ENABLING

The statements below describe elements of belief systems, feelings, and behaviors which can contribute to the complicated system of enabling. For each statement indicate the degree to which it is applicable to your experience of student alcohol and other drug problems.

YES	NO	SOMETIMES	
[ ]	[ ]	[ ]	1. I overlook obvious problems in students.
[ ]	[ ]	[ ]	2. I oversimplify problems related to alcohol or other drug abuse.
[ ]	[ ]	[ ]	3. I make decisions or take actions without formal training in the field of alcohol and other drug abuse.
[ ]	[ ]	[ ]	4. I view chemical dependency and other drug abuse primarily as a moral issue.
[ ]	[ ]	[ ]	5. In the staff lounge I gossip about the alcohol/drug problems of students.
[ ]	[ ]	[ ]	6. When I speak about those with alcohol drug problems my tone is accusatory.
[ ]	[ ]	[ ]	7. I typically view the chemically dependent person as "one of those people."
[ ]	[ ]	[ ]	8. I feel strangely uneasy, tense, or anxious after handling a situation involving alcohol/drug abuse.
[ ]	[ ]	[ ]	9. I focus blame for student drug problems somewhere other than on alcohol or other drugs.
[ ]	[ ]	[ ]	10. I lack clear and definite standards of performance and conduct for students.
[ ]	[ ]	[ ]	11. I have gradually lowered my expectations for acceptable student performance.
[ ]	[ ]	[ ]	12. I avoid confronting students' alcohol or other drug problems.
[ ]	[ ]	[ ]	13. I am uncomfortable bringing up the subject of alcohol or other drug use when working with a student.
[ ]	[ ]	[ ]	14. I feel that if I were more adequate as a professional I would be able to solve a student's alcohol/drug problems.

YES	NO	SOMETIMES	
[ ]	[ ]	[ ]	15. I do not report observed or suspected instances of student alcohol/drug use.
[ ]	[ ]	[ ]	16. I take disciplinary action without consulting other professionals in the school.
[ ]	[ ]	[ ]	17. I hesitate to involve others in a student's AODA problems out of fear that the student or the situation will be mishandled.
[ ]	[ ]	[ ]	18. I hesitate to take action on a student's AODA problem out of fear that I will not be supported by the school district.
[ ]	[ ]	[ ]	19. I do not take action on student alcohol/drug use because I fear a student will be mistreated.
[ ]	[ ]	[ ]	20. I am fearful of parent or community reactions if I take action on a student's alcohol/drug-related problems.
[ ]	[ ]	[ ]	21. I set a healthy example for students with respect to my own use of alcohol and other drugs.
[ ]	[ ]	[ ]	22. My own chemical use has resulted in behavior that I am not proud of.
[ ]	[ ]	[ ]	23. I wait for problem behavior to change by itself. I "endure."
[ ]	[ ]	[ ]	24. I protect a student from experiencing consequences by minimizing the seriousness of problems.
[ ]	[ ]	[ ]	25. I fail to admit the scope of drug abuse to protect the school system's image in the community.
[ ]	[ ]	[ ]	26. I think that I alone am in the best position to handle a troubled or AODA-involved student.
[ ]	[ ]	[ ]	27. I hesitate to confront a student with AODA-related problems for fear of jeopardizing my relationship with him/her.
[ ]	[ ]	[ ]	28. I verbally support some use of alcohol or other drugs by students.
[ ]	[ ]	[ ]	29. I consider their alcohol/drug use only as a last resort in helping troubled students.
[ ]	[ ]	[ ]	30. I attempt to control a student's alcohol/drug use through 'proofs,' appeals to logic or threats.
[ ]	[ ]	[ ]	31. I look the other way when students are using alcohol/drugs at school-sponsored functions.
[ ]	[ ]	[ ]	32. I believe that "cleaning up" alcohol/drug problems is what school counselors are supposed to do.

YES	NO	SOMETIMES	
[ ]	[ ]	[ ]	33. I believe that the kids I work with are really "above" alcohol/drug-related problems.
[ ]	[ ]	[ ]	34. I try to put distance between myself and those about whom I am worried.
[ ]	[ ]	[ ]	35. When students disclose AODA problems in family members, I fear the consequences of taking action.
[ ]	[ ]	[ ]	36. Discussions of, or involvement with, alcohol/drug problems are "too close to home."
[ ]	[ ]	[ ]	37. I fear my own position might be jeopardized by acting to address student AODA problems or issues.
[ ]	[ ]	[ ]	38. I regard some degree of student alcohol/drug use as acceptable.
[ ]	[ ]	[ ]	39. I make excuses for, cover-up, and even defend student drug use or other unacceptable behavior.
[ ]	[ ]	[ ]	40. I become frustrated at my inability to effect change in a student's behavior.
[ ]	[ ]	[ ]	41. I sometimes compromise my own value system in dealing with student alcohol/drug use.
[ ]	[ ]	[ ]	42. I maintain the "no talk rule" concerning alcohol/drug problems in students or their families.
[ ]	[ ]	[ ]	43. I believe that all students can stop using alcohol/drugs by themselves if they really want to.
[ ]	[ ]	[ ]	44. I believe that student AODA-related problems should be kept secret to protect their privacy.
[ ]	[ ]	[ ]	45. I avoid places in the school building or grounds where I know students use alcohol or other drugs.
[ ]	[ ]	[ ]	46. I fail to take action on AODA problems because I fear I will not be supported by others.
[ ]	[ ]	[ ]	47. I minimize or excuse student alcohol and other drug use.
[ ]	[ ]	[ ]	48. I believe there is no reason for the school to be involved in solving students' alcohol/drug problems.
[ ]	[ ]	[ ]	49. I have purchased alcohol or other drugs for students, or allowed them to use them in my presence at school-sponsored activities.
[ ]	[ ]	[ ]	50. I have ignored the AODA-related problems of staff.

QUOTATIONS

No one dies from chemical dependency without the (unwitting) help of at least one other person.

* * * * * * * * * * * * *

Only to the extent that an organism (person, family, institution or community) becomes aware of itself will it know how to change.

Overhead
Transparency

SESSION IX CHANGING SYSTEMS' ENABLING PATTERNS: THE STUDENT ASSISTANCE PROGRAM

OBJECTIVES: Participants will be able to

- Reach consensus on a philosophical approach to developing an SAP in their district.
- Define student assistance program (SAP).
- Describe key elements and functions of a student assistance program.

MATERIALS NEEDED:

- Transparencies "Picasso Quotation," "Rationale for AODA Focus in SAP," "Basic Functions of SAP," "Philosophy Statement," "Policy," "Procedures," "Intervention Flow Chart," "Behavior Report Form," and "Student Assistance Program Basic Elements"
- Overhead projector
- Handouts: Sample worksheet for "A Consensus-Seeking Task"

ACTIVITIES:

1. Conduct "A Censensus-Seeking Task" activity.
2. Trigger activity: Define focus for SAP.
3. Lecture presentation describing the elements and function of an SAP.

INTERVENTION LEVEL I: TRAINING MODULE

Session IX

Activity 1

TIME	PURPOSE	SETTING	MATERIAL
60-90 Minutes	Assist participants to reach consensus on a philosophical approach to developing an S.A.P. in their district	Small group discussion (20 members in each group)	°Worksheet °Writing surface °Pens/Pencils

PROCEDURE

1. Divide group into groups of 15-20 members.
2. Have groups select a chairperson and recorder.
3. Instruct the groups to work through Phase I of "A Consensus-Taking Task."
4. Time permitting, have a representative from each group report their results to the large group.
5. Process the experience in the large group.

Supplement 4.1

PROGRAM PHILOSOPHY: A CONSENSUS-SEEKING TASK

I. GOALS:

A. To allow participants to discover components of their belief system regarding alcohol and other drug abuse and the school's role in coping with AODA-related problems;

B. To seek a consensus of beliefs shared by the group;

C. To promote the development of a belief system which will support an effective student assistance program;

D. To promote team-building and cohesiveness in a planning group.

II. PARTICIPANTS:

The process works well, within the time constraints allowed, with a group of approximately 20 persons. The task can be presented to several different types of groups: school staff, Boards of Education, a community task force, or a joint school/community group. For the purpose of the exercise, assume a joint school/community group is meeting to examine the form a student assistance program should take for its school. The group might be constituted as follows:

Board of Education members (2)
Superintendent of Schools
Director of Instruction
Director of Pupil Services
High School Principal(s)
Junior High School Principal(s)
Elementary School Principal(s)
Guidance Counselor(s)
School Social Worker(s)
School Psychologist(s)
Teacher(s)
Parents
Student(s)
Alcohol/drug agency representative(s)
Police Officer(s)
Clergy

It is advisable to have persons familiar with the field of alcohol and other drug abuse, and with student assistance programming, in attendance as resource persons who can provide information and clarification to committee members. One person must function as "chairperson" for the meeting. The chairperson or another can function as recorder (see below).

III. TIME:

Approximately one hour is needed for each Phase, with a half-hour break between.

IV. MATERIALS:

For Phase I, booklets should be made up for participants, consisting of each of the statements on the Sample Statements Worksheet, one per page. For Phase II the group should have access to a typewriter and a copy machine.

V. PHYSICAL SETTING:

The most effective meetings occur with participants seated around tables or desks arranged in a large circle or square.

VI. PROCEDURE:

Phase I. The chairperson of the meeting begins by explaining the goals of the meeting. The purpose is to seek those areas where the group is in agreement, and/or to phrase ideas in ways that maximize consensus. The goal is not to decide "right or wrong" positions.

The chairperson distributes one of the Statements tablets to each participant. Everyone is to read through the statements one at a time and indicate on each page whether they agree or disagree with the statement as it is written. If they disagree with it, they are to re-word the statement so that they are in agreement with it where possible. Group members should be cautioned to rephrase items so they can support or agree with them, and not so that others will.

When everyone has finished, the chairperson goes through the tablet, one item at a time, and asks for a raise of hands of those agreeing and disagreeing. (1) If everyone expresses agreement, the chairperson notes that on her copy. (2) If one or more people express disagreement, they express their revised language. The goal is to arrive at language which the entire group can agree with or agree to support. The chairperson notes the changes in language on his copy. (3) If everyone disagrees with a statement, or if consensus on language for a particular item cannot be reached, the chairperson notes that the item is to be "rejected" on her copy.

When all the items have been covered, the chairperson or recorder takes the master copy and types up the accepted statements in their final form. He may type them as a list, or may want to group related items together in paragraph form.

Phase II. When the "accepted" statements have been retyped, copies are made and distributed to each participant. The group is asked to read the document (or the chairperson may read it aloud).

Following the reading, group members are to suggest additional changes in wording, vocabulary, or order for the statements. The chairperson keeps track of suggested changes on his copy, and includes only those agreed to by a consensus of the entire group. The document is re-typed and copies made for each participant.

VII. PROCESS:

The role of the leader, or chairperson, is to promote the movement of the group toward consensus on each item, and on the final form and "flavor" of the document which emerges in Phase II. She should watch time carefully, and should move on to the next item if a consensus does not develop.

Alcohol/drug resource people, or others in the group with specialized backgrounds should be consulted to answer questions when they arise with respect to individual items (e.g., "What is chemical dependency?" or "Do we know how many kids are smoking marijuana?").

Lengthy or heated debates should be avoided in favor of seeking the minimal common ground upon which group members can initially agree.

The document or list which emerges is often used as a component of policy language which is subsequently developed for the student assistance program. Often it is possible to append to the document specific recommendations or conclusions.

VII. VARIATIONS:

As an alternative to trying to accomplish both phases in one meeting, group members can be given the statements and directions beforehand. More group time may then be spent in processing consensual items.

Group members may also be invited to submit additional comments for reaction by the entire group as a part of Phase I.

The process can be adapted to any set of "statements," and to any meeting where group consensus is an important prerequisite to group action.

SAMPLE STATEMENTS WORKSHEET

The following are sample statements which may be printed on individual pages of a booklet for distribution to group members. Many statements could easily be added.

****

---

1. The use of alcohol and other drugs leads to alcoholism or other chemical dependencies.

[ ] Agree [ ] Disagree

---

2. The role of the school is to teach responsible drinking.

[ ] Agree [ ] Disagree

---

3. The _____ School District recognizes that the use of alcohol and other drugs is becoming increasingly commonplace among students.

[ ] Agree [ ] Disagree

---

4. The _____ School District believes that it has the major responsibility for helping students with alcohol and other drug problems.

[ ] Agree [ ] Disagree

---

5. Alcoholism and other chemical dependencies are illnesses which are most successfully treated when identified early and given appropriate treatment.

[ ] Agree [ ] Disagree

---

6. From 25% to 35% of _____ School District's students are affected by their own harmful chemical use or by that of people close to them.

[ ] Agree [ ] Disagree

---

7. The problems associated with youthful drug abuse and the stress of living in a chemically dependent family represent the most serious and prevalent threat to the health and welfare of the nation's youth.

[ ] Agree [ ] Disagree

8. Since only a few students get into trouble with their drug use, some drug use by students can be condoned as responsible, mature or healthful.

[ ] Agree [ ] Disagree

---

9. The school should apply its limited resources toward prevention rather than toward problems that have already developed.

[ ] Agree [ ] Disagree

---

10. The school should apply its limited resources toward intervening with those kids in trouble, rather than toward those without problems.

[ ] Agree [ ] Disagree

---

11. It is proper for the school system to become trained in the treatment of alcohol/drug problems to provide this service to students in school.

[ ] Agree [ ] Disagree

---

12. The major responsibility for the drug problems in this community lies with parents and the police.

[ ] Agree [ ] Disagree

---

13. The major focus of an alcohol/drug program should be on the high school. Such problems do not affect children in the elementary grades.

[ ] Agree [ ] Disagree

---

14. The best solution to our drug problems is to hire a drug expert to solve them in the high school.

[ ] Agree [ ] Disagree

---

15. The school should endorse some drinking by students if the alcohol is provided by parents and if the drinking is supervised.

[ ] Agree [ ] Disagree

INTERVENTION LEVEL I: TRAINING MODULE

Session IX

Activity 2

TIME	PURPOSE	SETTING	MATERIAL
30 Minutes	Provide trigger activity to define focus for S.A.P.	Large group	Transparencies: "Picasso Quotation" "Rationale for AODA Focus" "Basic Functions of SAP"

PROCEDURE

1. Show transparency "Picasso Quotation." Indicate to participants that student assistance programs mean many things to different people.

2. Outline general distinction between "Broad-brush" and "Alcohol and Other Drug Abuse Specific" focus in SAP's.

3. Present rationale for strong AODA focus using transparency "Rationale for AODA Focus." (For background information on this topic refer to One Step Ahead; pp. 67-68).

4. Define common functions of all SAP's using transparency "Basic Functions of SAP." (For background information on this topic refer to One Step Ahead; pp 8-11, 63-64, and chapters 6-7: When Chemicals Come to School; pp 96-98 and chapters 7-12).

RATIONALE FOR AODA FOCUS IN SAP

- THERE IS A GREAT AMOUNT OF SCHOOL-RELATED DRUG ACTIVITY.

- DRUG PROBLEMS SPREAD IN THE SCHOOL ENVIRONMENT.

- DRUGS CAN BE THE PREFERRED "CALLING CARD" FOR OTHER PERSONAL PROBLEMS.

- DRUG PROBLEMS CAN BE SYMPTOMATIC OF OTHER SERIOUS PROBLEMS.

- NO OTHER SINGLE PROBLEM AFFECTS THE STAFF OF A SCHOOL DISTRICT AS MUCH AS DO ALCOHOL AND OTHER DRUG- RELATED PROBLEMS.

Overhead
Transparency

BASIC FUNCTIONS OF SAP

IDENTIFICATION

DATA GATHERING AND ASSESSMENT

REFERRAL

APPROPRIATE USE OF THE CONTINUUM OF CARE

SUPPORT IN MAINTAINING HEALTHY CHANGES

CASE MANAGEMENT

Overhead
Transparency

"PICASSO QUOTATION"

One day the husband of a woman whose portrait was being painted by Picasso called at the artist's studio. "What do you think?" asked the painter, indicating the newly finished picture. "Well," said the husband, trying to be polite, "it isn't how she really looks." "Oh," said the artist, "and how does she really look?" The husband decided not to be intimidated, "Like this," he said, producing a photograph from his wallet. Picasso studied the photograph. "Mmm...," he said, "Small isn't she?"

Overhead
Transparency

INTERVENTION LEVEL I: TRAINING MODULE

Session IX

Activity 3

TIME	PURPOSE	SETTING	MATERIAL
60-90 Minutes	Describe development of SAP from philosophy to policy to procedures for operation	Large group	Transparencies: "Philosophy Statement" "Policy" "Procedures" "Intervention Flow Chart" "Behavior Report Form" "Student Assistance Program Basic Elements" Procedure Guidelines

PROCEDURE

1. Using the transparencies "Philosophy Statement," "Policy and Procedures," in just that sequence describe the development of an SAP. For preparation of this segment refer to When Chemicals Come to School; chapter 6, 7, 12 and 19.

2. Describe building based Core Team model for SAP. (Refer to Alliance for Change. pp 112-125, and When Chemicals Come to School, chapter 6).

3. Using the transparencies "Intervention Flow Chart" and Behavior Report Form" describe how a building Core Team might manage a referral through three levels of intervention. This presentation will require that you follow a hypothetical case from initial referral through the steps indicated on the flow chart. The handout "Procedures for Referring Students to Student Assistance Program" provides narrative elaboration of the steps detailed on the flow chart. For supplemental reading refer to When Chemicals Come to School, chapter 8.

4. Summarize and review highlights of this presentation with use of transparency "Student Assistance Program Basic Elements".

5. Respond to participant's questions and concerns.

PHILOSOPHY STATEMENT

- OPENS THE DOOR TO IDENTIFICATION OF THE SCHOOL'S ROLE FOR PREVENTION AND INTERVENTION SERVICES

- PRESENTS A STRONG ALCOHOL/DRUG FOCUS

- EXPLAINS THE SHARED RESPONSIBILITY FOR A SCHOOL/COMMUNITY RESPONSE

Overhead Transparency

POLICY

. DEFINES THE SCOPE OF PREVENTION EDUCATION K - 12

. ESTABLISHES DUE PROCESS FOR ALCOHOL/DRUG OFFENSES ON AND OFF CAMPUS:

- USE

- INTOXICATION

- POSSESSION

- SALE/DISTRIBUTION

. OFFERS HELP THROUGH REFERRAL TO A SAP

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. DEFINES FOR A SAP:

- HOW REFERRALS ARE MADE

- WHAT HAPPENS ONCE A REFERRAL IS MADE

- FOLLOW-UP TO THE REFERRAL

. SPECIFIES MEASURES FOR CONFIDENTIALITY

. PLACES RESPONSIBILITY FOR OPERATION OF THE PROGRAM WITH THE BUILDING ADMINISTRATOR

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PROCEDURES

ANSWERS THE QUESTION: "HOW DOES THE PROGRAM OPERATE IN EACH BUILDING?"

. SPELLS OUT STAFF ROLES FOR:

- OBSERVED USE
- SUSPECTED USE
- INTOXICATION
- AFFECTED OTHERS

. OUTLINES THE SAP RESPONSE TO ABOVE REFERRALS

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PROVIDES CLEAR PROCEDURES FOR:

- RE-ENTRY FROM TREATMENT

- COMMUNITY REFERRALS

- STUDENT SELF-REFERRALS

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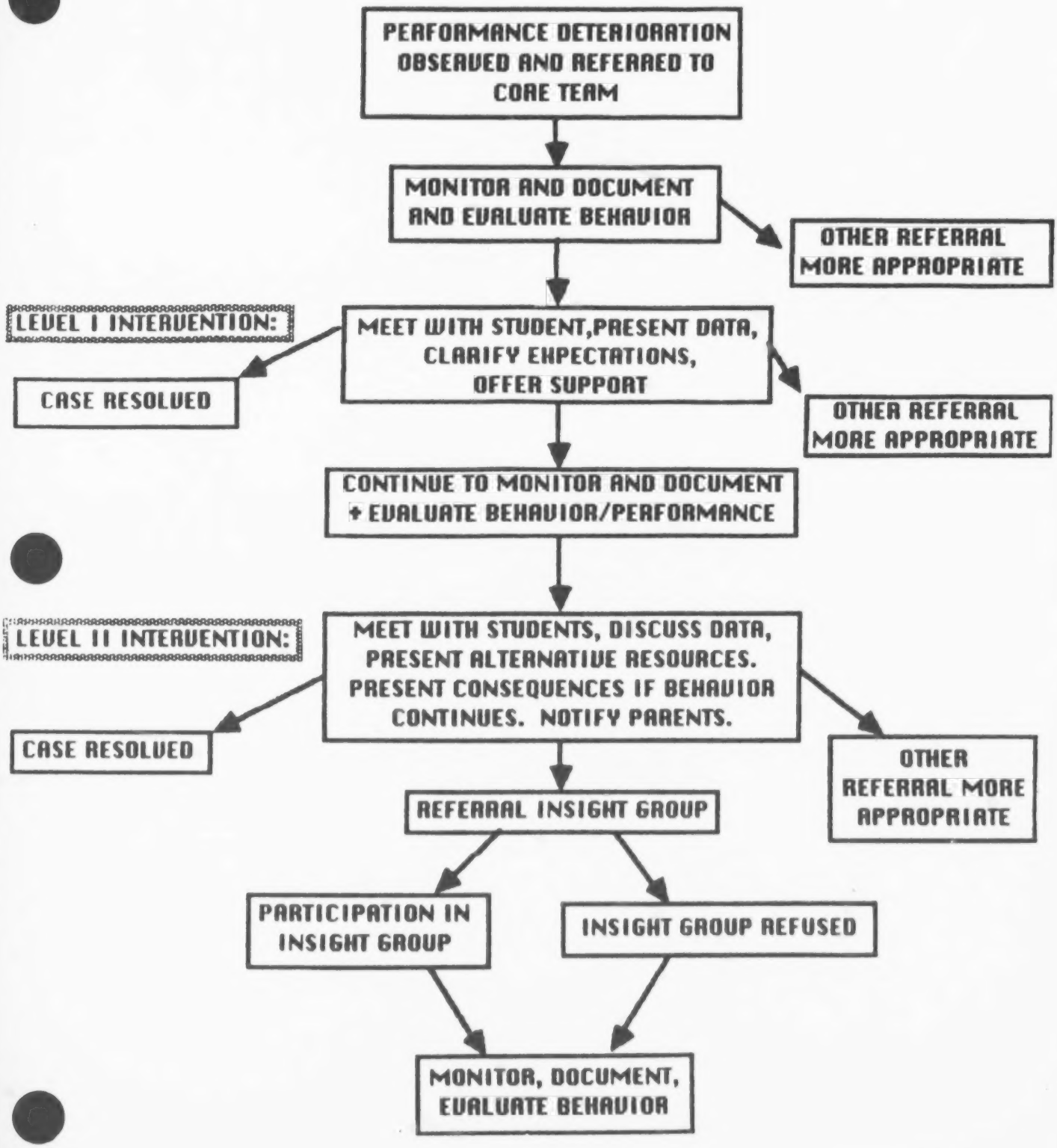
INTERVENTION FLOW CHART


PERFORMANCE DETERIORATION OBSERVED AND REFERRED TO CORE TEAM
MONITOR AND DOCUMENT AND EVALUATE BEHAVIOR
OTHER REFERRAL MORE APPROPRIATE
LEVEL I INTERVENTION:
MEET WITH STUDENT, PRESENT DATA, CLARIFY EXPECTATIONS, OFFER SUPPORT
CASE RESOLVED
OTHER REFERRAL MORE APPROPRIATE
CONTINUE TO MONITOR AND DOCUMENT + EVALUATE BEHAVIOR/PERFORMANCE
LEVEL II INTERVENTION:
MEET WITH STUDENTS, DISCUSS DATA, PRESENT ALTERNATIVE RESOURCES. PRESENT CONSEQUENCES IF BEHAVIOR CONTINUES. NOTIFY PARENTS.
CASE RESOLVED
OTHER REFERRAL MORE APPROPRIATE
REFERRAL INSIGHT GROUP
PARTICIPATION IN INSIGHT GROUP
INSIGHT GROUP REFUSED
MONITOR, DOCUMENT, EVALUATE BEHAVIOR

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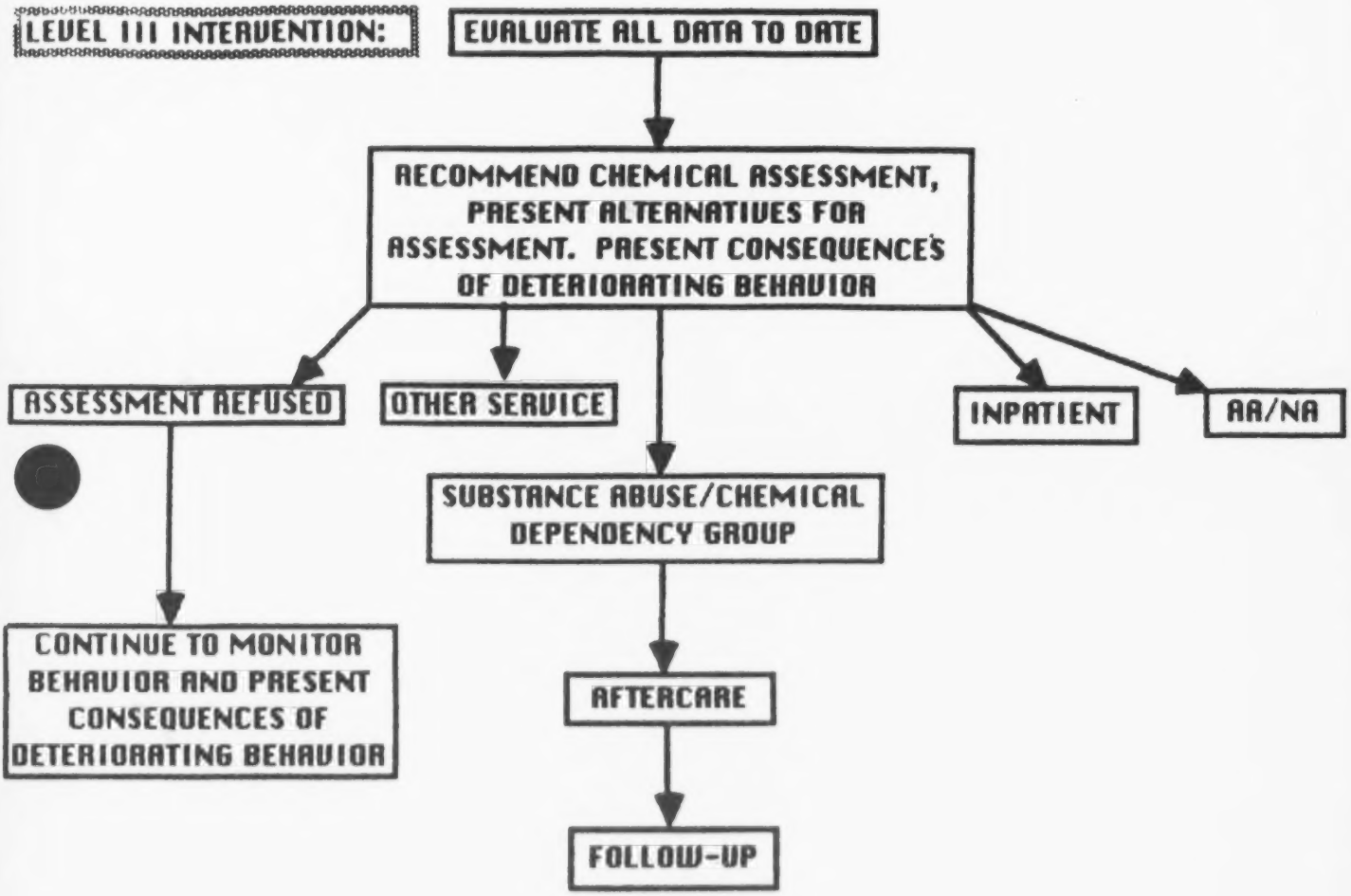

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STUDENT ASSISTANCE PROGRAM

BEHAVIOR REPORT

Student _____ Dates of Observation _____

Grade _____ Observer _____

Return to _____ Date to Return By _____

Period you have student _____

Check Appropriate Response

A. GRADES

___ Lower Grades-Lower Achievement
___ Academic Failure
___ Always Behind in Class
___ Lack of Motivation-Apathy

B. SCHOOL ATTENDANCE

___ Absenteeism
___ Tardy(___ Times to Date)
___ On Absence List but Seen in School
___ Frequently Requesting to be Out of Class (Trips to Restroom, Etc.)
___ Frequent Visits to Nurse or Counselor

C. PHYSICAL SYMPTOMS

___ Sleeping in Class
___ Frequent Physical Complaints
___ Frequent Physical Injuries
___ Staggering or Stumbling
___ Smelling of Alcohol or Marijuana
___ Coordination Problems
___ Glassy, Bloodshot Eyes
___ Slurred Speech

D. BEHAVIOR

___ Constant Defiance of Rules
___ Frequent Discipline Referrals/Action
___ Fighting
___ Cheating
___ Excessive Nervousness
___ Withdrawn (Loner)
___ Verbal Abuse
___ Frequent Crying
___ Excessive Forgetfulness
___ Frequently Tired
___ Talks Freely About Drug/Alcohol Use
___ Erratic Behavior/Mood Swings
___ Change in Friends
___ Change in Appearance
___ Sudden Popularity
___ Older Social Group
___ Disoriented Sense of Time
___ Carries Large Amounts of Money
___ Depression
___ Acts Defensive
___ Increasing Non-Involvement
___ Home Problems of Concern

If you think that this student is experiencing a problem(s) please indicate your estimation of the severity of the problem(s) on a scale of 1-10. (10 should be used for the most serious, 1 for the least serious). ☐

Comments: _____

_____

_____

_____

_____

If behavior is noted at times other than those listed above, please note: _____

_____

_____

Thank you for your time and concern

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PROCEDURE FOR REFERRING STUDENTS TO STUDENT ASSISTANCE PROGRAM

1. When behavior is observed in a student which indicates a possible problem, school personnel should refer student to building level Core Teams using behavior report form.

2. Upon receipt of a behavior report form, the Core Team will determine need for additional data.

3. Additional data will be obtained from appropriate school personnel using Behavior Report form.

4. Core Teams will then evaluate data relating to behavior and determine most appropriate course of action. A Special Services member of the Core Team will evaluate data to determine need for a Special Services referral.

5. A Level One Intervention will be implemented. A Level One Intervention consists of meeting with student, discussing data from referral forms, clarifying expectations, and offering support. Discussion will focus on problem behavior. The Core Team will choose a staff member known to and respected by the student.

6. If after the Level One Intervention, additional monitoring of behavior indicates that no further problem exists, the case will be closed.

7. If behavior seems, at any time, to indicate a problem requiring the services of a group other than the Core Team an appropriate referral will be made.

8. If after the Level One Intervention, additional monitoring indicates that the behavior continues or deteriorated, a Level Two Intervention will be implemented. A Level Two Intervention consists of meeting with the student. If all available data suggest a problem related to substance abuse, this information will be presented to the student. The student will be informed of the consequences of the behavior. The student's parents will be notified. Alternatives will be presented and participation in an insight group will be strongly recommended.

   If the available data suggest that a problem is unrelated to substance abuse, an appropriate referral will be made.

9. If after a Level Two Intervention additional monitoring of behavior indicates no further problems exist, the case will be closed.

10. If after a Level Two Intervention, additional monitoring indicates that the behavior has continued or deteriorated, a Level Three Intervention will be implemented.

11. If after the school has provided all possible support, the Core Team determines, based on all the data available, that the school cannot provide any further meaningful or effective assistance a Level Three Intervention will be implemented. Level Three Intervention consists of presenting external alternatives for substance abuse assessment. Selected Core Team members will meet with the student and his/her parents to fully inform them of the findings of the Core Team, their assessment of the problem, recommendations regarding assessment and treatment as well as the consequences of continues deteriorating behavior.

12. The Core Team will work closely at all times with building level special services committees, guidance counselors and other appropriate staff to ensure the optimal intervention.

13. At such times when behavior indicates an emergency situation, appropriate action will be taken.

14. All information involved in Core Team action will be held strictly confidential.

15. All behavior reports will be destroyed at the end of the school year.

STUDENT ASSISTANCE PROGRAM
BASIC ELEMENTS

SYSTEM-WIDE CHEMICAL ABUSE POLICY

DESIGNATED PROGRAM COORDINATOR

IDENTIFICATION AND REFERRAL PROCEDURES

CONFIDENTIALITY

IN-SERVICE TRAINING

- STAFF
- STUDENTS
- PARENTS/COMMUNITY

IN-SCHOOL SUPPORT GROUPS

ON-GOING TRAINING AND EDUCATION

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(Expanded Bibliography for Introduction to Student Assistance Programming Trainer Manual)

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